

NORTH CAROLINA

Child Fatality Task Force

ANNUAL REPORT TO THE GOVERNOR AND GENERAL ASSEMBLY

FEBRUARY 2021 ■ RALEIGH, NC



Our Children Our Future **Our RESPONSIBILITY**

FEBRUARY 2021

The Honorable Roy Cooper
Governor, State of North Carolina

Distinguished Members of the North Carolina General Assembly

Child Fatality Task Force



Since 1991, the North Carolina Child Fatality Task Force has been charged with bringing to you “recommendations for changes to any law, rule, or policy that it has determined will promote the safety and well-being of children.” The Task Force studies North Carolina data related to child deaths and child well-being and each year hears dozens of presentations from experts who share detailed data about various causes of death and evidence showing the effectiveness of various prevention strategies.

Recommendations in this year’s report cover a range of issues from strengthening the statewide child fatality prevention system and preventing youth suicide and firearm-related deaths to supporting programs and policies proven to reduce infant mortality and a law proven to reduce motor vehicle fatalities. Many of the recommendations in this year’s report are being repeated from prior years because they have not yet advanced but are still seen by the Task Force as being important strategies for preventing child deaths and maltreatment and promoting child well-being.

During the 2020-2021 study cycle of the Task Force, there were multiple presentations addressing the impact of the pandemic on children and families and the Task Force learned how the pandemic has created increased risks and urgency for advancing several of its recommendations. You will see in this report some of the data illustrating the pandemic’s impact and these increased risks.

Now, in these most challenging times of a global pandemic, North Carolina children who can’t speak for themselves need more than ever for their voices to be heard through the North Carolina Child Fatality Task Force. The Task Force is their voice to tell state leaders that there are laws that can be changed and programs that can be funded that will literally save children’s lives.

At the same time, the Task Force finds itself more challenged than ever to advance these policies in an environment where budgets are tight and there are so many competing needs in North Carolina. It should be noted that many of the funding recommendations in this report are for amounts that, in the scheme of the annual state budget, are fairly described as tiny and yet have the potential to save many lives.

Our hope is that North Carolina leaders will view these recommendations not as “competing” among many needs in our state but will instead recognize that prioritizing the advancement of these policies to save children’s lives is a means by which we strengthen all of our communities and strengthen our state’s ability to meet the needs of its most vulnerable citizens.

Sincerely,

Karen McLeod
CHAIR

Kella Hatcher
EXECUTIVE DIRECTOR

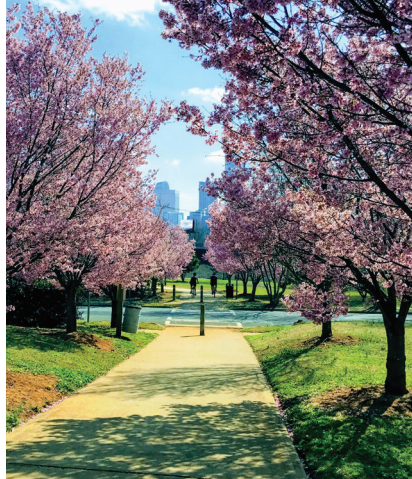


Table of Contents

NC Child Fatality Task Force Mandate, Study Process, and Ongoing Efforts	2
NC Child Fatality Task Force 2021 Action Agenda	10
Explanation of CFTF 2021 Action Agenda	13
• Recommendations to strengthen the statewide Child Fatality Prevention System to increase the system’s ability to prevent child abuse, neglect, and death	13
• Recommendations to prevent youth suicide and firearm-related deaths and injuries to children	20
• Recommendations to prevent infant deaths	30
• Recommendations on workplace supports to strengthen child and family health, well-being, and economic stability.	36
• Recommendations to strengthen education and awareness around child abuse and neglect reporting	43
• Recommendations and administrative efforts to prevent motor vehicle-related injuries and deaths to children	47
• Recommendation to prevent harm to youth caused by tobacco and nicotine use	50
Legislative History and Accomplishments	52
Report from North Carolina Child Fatality Prevention Team	69
Child Fatality Task Force Contact Information and Leadership Structure.	71
NC Child Fatality Task Force Members	72

NC Child Fatality Task Force Mandate, Study Process, and Ongoing Efforts

The North Carolina Child Fatality Task Force (CFTF or “Task Force”) derives its authority from Article 14 of the North Carolina Juvenile Code. The Task Force is part of the broader statewide Child Fatality Prevention System created in 1991. The charge of the system is: to develop a community-wide approach to child abuse and neglect; to study and understand causes of childhood death; to identify gaps in service delivery in systems designed to prevent child abuse, neglect, and death; and to make and implement recommendations for laws, rules, and policies that will support the safe and healthy development of children and prevent future child abuse, neglect, and death. This system has local and state-level teams that review individual cases of child deaths. The Task Force is the “policy arm” of the system and does not conduct individual case reviews.

The Task Force studies and reports on data related to child deaths, hears from experts and leaders about evidence-driven prevention initiatives, receives information and recommendations from teams who review child deaths, and engages in discussion to formulate recommendations submitted annually to the Governor and NC General Assembly. These recommendations are aimed at the prevention of child death and maltreatment and at supporting the safety and well-being of children.

During its most recent study cycle, the Task Force had a total of twelve meetings, including nine committee meetings and three full Task Force meetings where attendees heard more than 65 presentations. For this study cycle, all meetings were held virtually due to the COVID-19 pandemic. Most Task Force meetings for this study cycle included presentations or parts of presentations aimed

at sharing information about the impact of the COVID-19 pandemic on children and families.

Presentation topics addressed at meetings of the Task Force and/or its three committees for the 2020-2021 study cycle included the following:

Presentation topics related to pandemic impact on children and families

- Current data and what we know so far about children and COVID-19
- Injury and COVID-19: a data update
- The child and family impact of COVID-19 (data points on economic impact, food and housing insecurity, internet access, and more)
- Pregnancy, infants, and COVID-19
- COVID-19 and the perinatal experience
- Updates and lessons learned from MCH telehealth implementation in times of COVID-19
- Motor vehicle data: recent trends and crash data
- Mental health data related to COVID-19 impact
- Impacts of COVID-19 on student wellbeing and efforts to address student mental health in schools

All other presentation topics

Related to infant mortality and perinatal health:

- Workplace accommodations for pregnancy and lactation
- Infant safe sleep
- Perinatal tobacco use and QuitlineNC
- Update on Perinatal Health Strategic Plan with policy focus
- Update on Maternal Health Strategic Plan with policy focus

- Overview of March of Dimes Implicit Bias Training
- Kin Care and Safe Days Leave
- Paid Family Leave Insurance
- Doula in North Carolina

Related to youth suicide, youth mental health, and firearm safety:

- Local firearm safety initiative (Orange County Gun Safety Team)
- Data and perspective on the mental health needs of North Carolina students
- Suicide-related data and Task Force efforts on suicide prevention
- Division of Public Health work and grants related to suicide prevention
- Data on firearm-related deaths and injuries to children
- Division of Public Health work and grants related to firearm safety
- Safe storage of firearms as a public health strategy
- Child Fatality Task Force efforts on firearm safety education and awareness and access to lethal means

Related to child welfare:

- Infant safe surrender
- Child abuse and neglect reporting education and awareness
- Updates on child welfare reform and Family First Prevention Services Act
- North Carolina Child Fatality Review Team

Related to motor vehicle safety:

- Child passenger safety study
- Occupant Protection Task Force analysis related to child passenger safety
- Teen driving updates and trends
- Alcohol impaired driving prevention: ignition interlocks

Related to child health and safety generally:

- Child Fatality Prevention System restructuring and strengthening
- 2019 child death and infant mortality data from the NC State Center for Health Statistics

- Health equity and social determinants of health
- Recommendations from the State Child Fatality Prevention Team
- Youth Risk Behavior Survey data
- Youth nicotine use & prevention

Experts and leaders presenting to the Task Force and its committees during the 2020-2021 study cycle represented state and local agencies and academic institutions, as well as state, national, and community programs such as:

- A Better Balance
- Child Protective Services and Prevention, Division of Social Services, NCDHHS
- Child, Family, and Adult Services, NCDHHS
- Division of Mental Health, Developmental Disabilities and Substance Use Services, NCDHHS
- Duke University School of Medicine
- Edgecombe County Schools
- Governor's Highway Safety Program, NC Department of Transportation
- Injury and Violence Prevention Branch, Division of Public Health, NCDHHS
- Jordan Institute, UNC School of Social Work
- March of Dimes
- MomsRising
- NC Child
- NC Conference of District Attorneys
- NC Healthy Schools, NC Department of Public Instruction
- NC Institute of Medicine
- NC Medicaid, Division of Health Benefits, NCDHHS
- NC Occupant Protection Task Force
- Office of Minority Health and Health Disparities, NCDHHS
- Office of the NC Attorney General
- Office of the Secretary, NCDHHS
- Perinatal Health Strategic Plan Collaborative Team, Women's Health Branch, Division of Public Health, NCDHHS
- Women's Health Branch, Division of Public Health, NCDHHS

*The rate of child deaths in North Carolina **has decreased by 49%** since the 1991 creation of the Child Fatality Task Force & the broader Child Fatality Prevention System.*

- Prevent Child Abuse NC
- Safe Kids, Orange and Chatham Counties
- Safe Sleep NC, UNC Center for Maternal and Infant Health
- State Child Fatality Prevention Team, Office of the NC Chief Medical Examiner
- Tobacco Prevention and Control Branch, Division of Public Health, NCDHHS
- Town of Brevard Police Department
- Traffic Safety, NC Department of Transportation
- UNC Center for Maternal and Infant Health
- UNC Gillings School of Global Public Health
- UNC Health Care Trauma Program
- University of North Carolina Highway Safety Research Center
- Wake Forest School of Medicine
- Women's and Children's Health Section, Division of Public Health, NCDHHS

Task Force work is accomplished through three committees that prepare recommendations for consideration by the full Task Force. Committee participants include Task Force members as well as volunteers with subject matter expertise in the committee's area of focus.

The **Intentional Death Prevention Committee** studies homicide, suicide, and child maltreatment. For this study cycle this committee focused on and developed recommendations and administrative items in the following areas: suicide prevention, student mental health, strengthening education and awareness around child abuse and neglect reporting, and strengthening North Carolina's infant safe surrender law.

The **Perinatal Health Committee** studies infant mortality and women's health. This committee's work and recommendations for the 2020-2021 study cycle address infant safe sleep, perinatal tobacco use, workplace measures to strengthen child and family well-being, and continuing a set of recommendations aimed at strengthening the statewide Child Fatality Prevention System.

The **Unintentional Death Prevention Committee** studies unintentional injury and death. For the 2020-2021 study cycle, this committee examined and addressed recommendations and administrative items related to youth nicotine use prevention, firearm safe storage education and awareness, impaired driving, and child passenger safety.

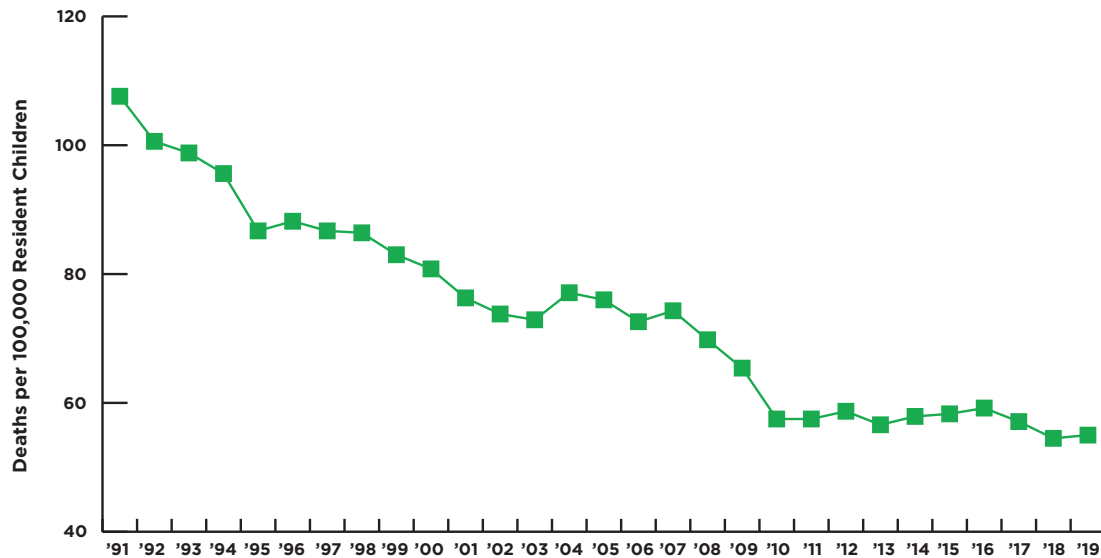
Agendas, minutes, and presentations for all Task Force meetings and committee meetings can be found on the Task Force website which is hosted on the website for the General Assembly: www.ncleg.gov/DocumentSites/Committees/NCCFTF/Homepage/index.html.

Explanations for each of the 2021 recommendations from the Task Force, including highlights of evidence to support the recommendations, can be found in this report on pages 13-51.

Child Fatality Task Force recommendations are set out in its yearly action agenda, and these recommendations are shared not only in the annual report of the Task Force, but they are also shared widely through broad communications about Task Force work and through the involvement of the Task Force Executive Director and other members of the Task Force Executive Committee in various state-level committees and initiatives.

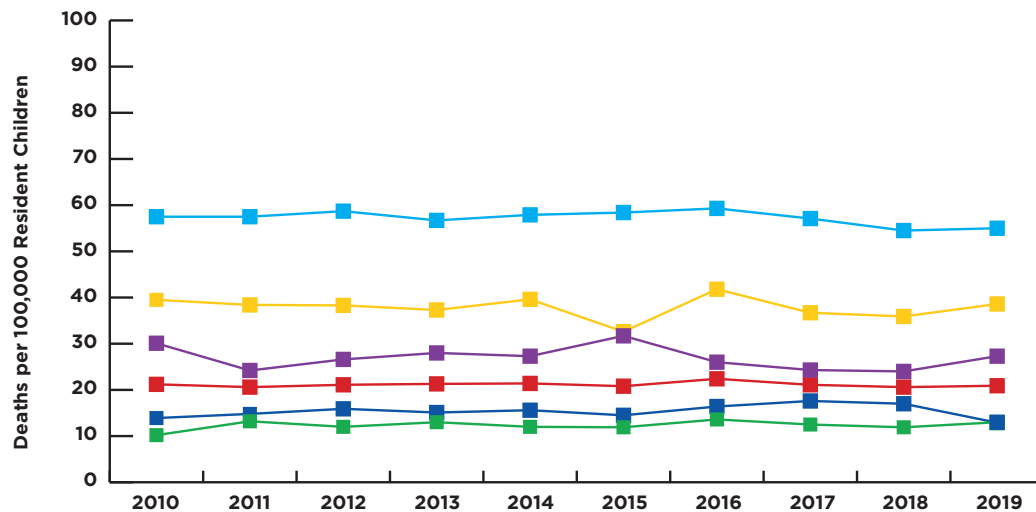
The Child Fatality Task Force Executive Committee thanks all Task Force Members, contributing experts, and community volunteers who devoted their time and expertise to Task Force work. Their efforts and commitment to protecting the children of North Carolina are reflected in the 2021 Action Agenda.

FIGURE 1. 1991-2019 TRENDS IN NORTH CAROLINA RESIDENT CHILD DEATH RATES† AGES BIRTH THROUGH 17 YEARS



1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
107.6	100.6	98.8	95.6	86.7	88.2	86.7	86.4	83.0	80.8	76.3	73.8	72.9	77.1	76.0	72.6	74.3	69.8	65.4	57.5	57.5	58.7	56.7	57.9	58.4	59.3	57.1	54.5	55.0

FIGURE 2. 2010-2019 TRENDS IN NORTH CAROLINA RESIDENT CHILD DEATH RATES† BY AGE GROUP



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
TOTAL Ages 0-17	57.5	57.5	58.7	56.7	57.9	58.4	59.3	57.1	54.5	55.0
Ages 1-4	30.1	24.2	26.6	28.0	27.3	31.7	26.0	24.3	24.0	27.3
Ages 5-9	10.2	13.2	12.0	13.0	12.0	11.9	13.6	12.5	11.9	13.0
Ages 10-14	13.9	14.8	15.9	15.1	15.6	14.5	16.4	17.6	17.0	12.9
Ages 15-17	39.5	38.4	38.3	37.3	39.6	32.6	41.8	36.7	35.9	38.6
(Excl. Infants) Ages 1-17	21.2	20.6	21.1	21.3	21.4	20.8	22.4	21.1	20.6	20.9

† Child death rates prior to 2019 have been recalculated using the latest available population data

Note on Cause of Death Figures: Numbers in this report from the State Center for Health Statistics (SCHS) may differ slightly from numbers reported later by the Office of the Chief Medical Examiner (OCME). The SCHS bases its statistics on death certificate coding only, and closes out annual data at a specific point in time. The OCME makes its determinations utilizing a variety of information sources when conducting its death reviews, does not close out their data, and some of its cases are still pending when the State Center for Health Statistics closes their annual data files. Therefore, the cause and manner of death determined by the OCME may be modified based on OCME review after the time period during which the SCHS finalizes annual data files.

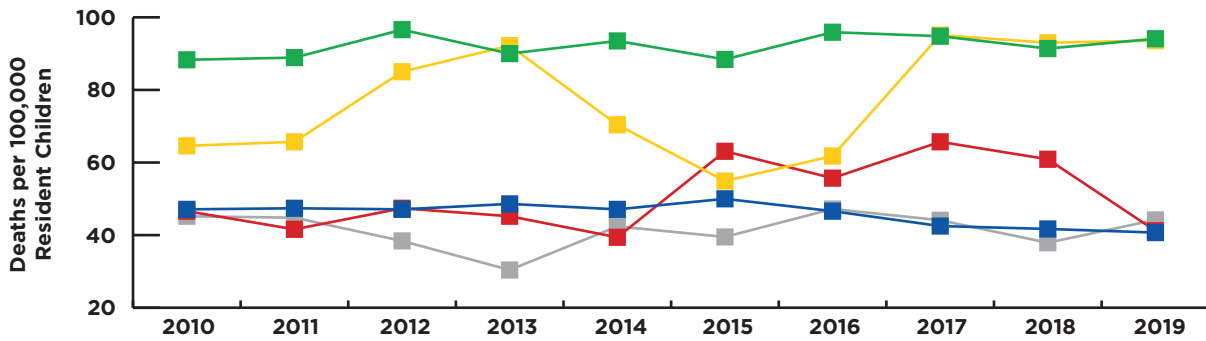
TABLE 1. 2019 NC RESIDENT CHILD DEATHS BY AGE GROUP & CAUSE OF DEATH

Cause of Death Category:	TOTAL AGES 0-17		AGE GROUP (years)									
	N	%	Infants		1-4		5-9		10-14		15-17	
			N	%	N	%	N	%	N	%	N	%
Perinatal Conditions	423	33.4	422	99.8	1	0.2	0	0.0	0	0.0	0	0.0
... Short Gestation/Low Birthweight	151		151		0		0		0		0	
... Maternal Complications	105		105		0		0		0		0	
... All Other Perinatal Conditions	167		166		1		0		0		0	
Medical Conditions	252	19.9	83	32.9	62	24.6	44	17.5	27	10.7	36	14.3
... Malignant Neoplasms (Cancer)	44		1		10		13		9		11	
... Heart Disease	26		12		6		2		3		3	
... Chronic Lower Respiratory Diseases	9		1		3		2		1		2	
... Septicemia	13		4		4		3		1		1	
... Pneumonia/Influenza	10		3		1		2		3		1	
... All Other Medical Conditions	150		62		38		22		10		18	
Birth Defects	172	13.6	145	84.3	13	7.6	5	2.9	5	2.9	4	2.3
... Circulatory System	38		31		5		0		1		1	
... Nervous System	26		14		7		2		3		0	
... Respiratory System	15		14		0		0		0		1	
... All Other Birth Defects	93		86		1		3		1		2	
Motor Vehicle Injuries	88	7.0	1	1.1	16	18.2	15	17.0	17	19.3	39	44.3
Other Unintentional Injuries	91	7.2	32	35.2	20	22.0	11	12.1	12	13.2	16	17.6
...Suffocation/Choking/Strangulation	35		26		6		1		2		0	
...Drowning	25		1		7		6		4		7	
...Poisoning	8		2		1		0		0		5	
...Bicycle	1		0		0		0		1		0	
...Firearm	4		2		0		0		1		1	
...Smoke, Fire & Flames	5		0		1		2		0		2	
...All Other Accidental Injuries	13		1		5		2		4		1	
Suicide	36	2.8	0	0.0	0	0.0	0	0.0	15	41.7	21	58.3
... by Firearm	15		0		0		0		8		7	
... by Hanging	18		0		0		0		6		12	
... by Poisoning	1		0		0		0		0		1	
... All Other Suicides	2		0		0		0		1		1	
Homicide	56	4.4	10	17.9	8	14.3	6	10.7	5	8.9	27	48.2
... Involving Firearm	36		1		1		4		5		25	
... All Other Homicides	20		9		7		2		0		2	
All Other Causes of Death	147	11.6	117	79.6	14	9.5	1	0.7	5	3.4	10	6.8
TOTAL DEATHS	1,265	100.0	810	64.0	134	10.6	82	6.5	86	6.8	153	12.1

* Child death rates prior to 2019 have been recalculated using the latest available population data

Note on Cause of Death Figures: Numbers in this report from the State Center for Health Statistics (SCHS) may differ slightly from numbers reported later by the Office of the Chief Medical Examiner (OCME). The SCHS bases its statistics on death certificate coding only, and closes out annual data at a specific point in time. The OCME makes its determinations utilizing a variety of information sources when conducting its death reviews, does not close out their data, and some of its cases are still pending when the State Center for Health Statistics closes their annual data files. Therefore, the cause and manner of death determined by the OCME may be modified based on OCME review after the time period during which the SCHS finalizes annual data files.

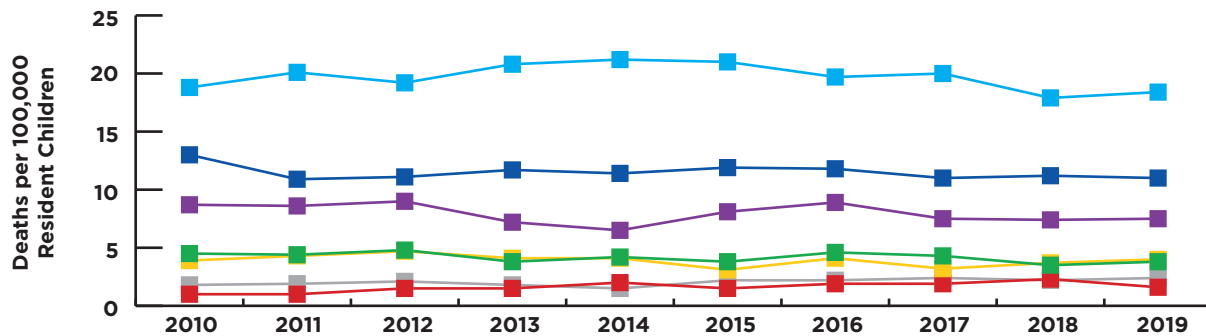
**FIGURE 3. 2010-2019 TRENDS IN NORTH CAROLINA RESIDENT CHILD DEATH RATES[†]
BY RACE/ETHNICITY, AGES BIRTH THROUGH 17 YEARS**



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Non-Hispanic White	47.1	47.4	47.1	48.6	47.1	50.0	46.6	42.5	41.7	40.7
Non-Hispanic Black	88.3	88.9	96.6	90.0	93.5	88.4	95.9	94.8	91.4	94.1
Non-Hispanic American Indian	64.6	65.7	85.0	92.2	70.4	54.9	61.8	95.1	93.0	93.6
Non-Hispanic Other	46.6	41.6	47.4	45.2	39.4	63.1	55.7	65.7	60.9	41.2
Hispanic	45.2	44.8	38.4	30.4	42.4	39.5	47.2	44.1	37.9	44.2

[†] Child death rates prior to 2019 have been recalculated using the latest available population data

**FIGURE 4. 2010-2019 TRENDS IN NORTH CAROLINA RESIDENT CHILD DEATH RATES[†]
FOR SELECTED CAUSES OF DEATH, AGES BIRTH THROUGH 17 YEARS**



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Perinatal Conditions	18.8	20.1	19.2	20.8	21.2	21.0	19.7	20.0	17.9	18.4
Birth Defects	8.7	8.6	9.0	7.2	6.5	8.1	8.9	7.5	7.4	7.5
Illnesses	13.0	10.9	11.1	11.7	11.4	11.9	11.8	11.0	11.2	11.0
Motor Vehicle Accidents	4.5	4.4	4.8	3.8	4.2	3.8	4.6	4.3	3.5	3.8
Other Accidents	3.9	4.3	4.7	4.1	4.1	3.1	4.1	3.2	3.7	4.0
Suicide	1.0	1.0	1.5	1.5	2.0	1.5	1.9	1.9	2.3	1.6
Homicide	1.8	1.9	2.1	1.8	1.5	2.2	2.2	2.4	2.2	2.4

[†] Child death rates prior to 2019 have been recalculated using the latest available population data

LEADING CAUSES OF CHILD DEATH BY AGE GROUP, NC RESIDENTS 2019

ALL AGES, 0-17			
Rank	Cause	Number	%
1	Conditions originating in the perinatal period	423	33.4%
2	Congenital anomalies (birth defects)	172	13.6%
3	Other Unintentional injuries	91	7.2%
4	Motor vehicle injuries	88	7.0%
5	Homicide	56	4.4%
6	Cancer	44	3.5%
7	Suicide	36	2.8%
8	Diseases of the heart	26	2.1%
9	Cerebrovascular disease	14	1.1%
10	Septicemia	13	1.0%
All other causes (Residual)		302	23.9%
Total Deaths --- All Causes		1,265	100.0%

INFANTS			
Rank	Cause	Number	%
1	Congenital anomalies (birth defects)	145	17.9%
	Short gestation - low birthweight	145	17.9%
3	Maternal complications of pregnancy	61	7.5%
4	Complications of placenta, cord, and membranes	32	4.0%
	Other unintentional injuries	32	4.0%
6	Bacterial sepsis	29	3.6%
7	Diseases of the circulatory system	23	2.8%
8	Respiratory distress	19	2.3%
9	Intrauterine hypoxia and birth asphyxia	16	2.0%
	Neonatal hemorrhage	16	2.0%
All other causes (Residual)		292	36.0%
TOTAL DEATHS — ALL CAUSES		810	100.0%

AGES 1 TO 17			
Rank	Cause	Number	%
1	Motor vehicle injuries	87	19.1%
2	Other Unintentional injuries	59	13.0%
3	Homicide	46	10.1%
4	Cancer	43	9.5%
5	Suicide	36	7.9%
6	Congenital anomalies (birth defects)	27	5.9%
7	Diseases of the heart	14	3.1%
8	Septicemia	9	2.0%
9	Chronic lower respiratory diseases	8	1.8%
10	Pneumonia & influenza	7	1.5%
All other causes (Residual)		119	26.2%
TOTAL DEATHS — ALL CAUSES		455	100.0%

AGES 1 TO 4			
Rank	Cause	Number	%
1	Other Unintentional injuries	20	14.9%
2	Motor vehicle injuries	16	11.9%
3	Congenital anomalies (birth defects)	13	9.7%
4	Cancer	10	7.5%
5	Homicide	8	6.0%
6	Diseases of the heart	6	4.5%
7	Septicemia	4	3.0%
8	Anemias	3	2.2%
	Cerebrovascular disease	3	2.2%
	Chronic lower respiratory diseases	3	2.2%
	In-situ/benign neoplasms	3	2.2%
All other causes (Residual)		45	33.6%
TOTAL DEATHS — ALL CAUSES		134	100.0%

LEADING CAUSES OF CHILD DEATH BY AGE GROUP, NC RESIDENTS 2019

AGES 5 TO 9			
Rank	Cause	Number	%
1	Motor vehicle injuries	15	18.3%
2	Cancer	13	15.9%
3	Other Unintentional injuries	11	13.4%
4	Homicide	6	7.3%
5	Congenital anomalies (birth defects)	5	6.1%
6	Septicemia	3	3.7%
7	Chronic lower respiratory diseases	2	2.4%
	Diseases of the heart	2	2.4%
	Pneumonia & influenza	2	2.4%
10	Aortic aneurism and dissection	1	1.2%
	Cerebrovascular disease	1	1.2%
	In-situ/benign neoplasms	1	1.2%
	Pneumonitis due to solids & liquids	1	1.2%
All other causes (Residual)		19	23.2%
TOTAL DEATHS — ALL CAUSES		82	100.0%

AGES 15 TO 17			
Rank	Cause	Number	%
1	Motor vehicle injuries	39	25.5%
2	Homicide	27	17.6%
3	Suicide	21	13.7%
4	Other Unintentional injuries	16	10.5%
5	Cancer	11	7.2%
6	Congenital anomalies (birth defects)	4	2.6%
7	Diseases of the heart	3	2.0%
8	Chronic lower respiratory diseases	2	1.3%
9	Complications of medical and surgical care	1	0.7%
	In-situ/benign neoplasms	1	0.7%
	Nephritis, nephrotic syndrome, & nephrosis	1	0.7%
	Pneumonia & influenza	1	0.7%
	Pregnancy, childbirth, and puerperium	1	0.7%
	Septicemia	1	0.7%
All other causes (Residual)		24	15.7%
TOTAL DEATHS — ALL CAUSES		153	100.0%

AGES 10 TO 14			
Rank	Cause	Number	%
1	Motor vehicle injuries	17	19.8%
2	Suicide	15	17.4%
3	Other Unintentional injuries	12	14.0%
4	Cancer	9	10.5%
5	Congenital anomalies (birth defects)	5	5.8%
	Homicide	5	5.8%
7	Diseases of the heart	3	3.5%
	Pneumonia & influenza	3	3.5%
9	Anemias	1	1.2%
	Cerebrovascular disease	1	1.2%
	Chronic lower respiratory diseases	1	1.2%
	Complications of medical and surgical care	1	1.2%
	In-situ/benign neoplasms	1	1.2%
	Septicemia	1	1.2%
All other causes (Residual)		11	12.8%
TOTAL DEATHS — ALL CAUSES		86	100.0%

* Note: These tables use National Center for Health Statistics standards for classifying cause of death and may differ from tabulations presented in Table 1.

NC Child Fatality Task Force 2021 Action Agenda

Legislative “support” items receive the highest level of support from the CFTF.

Legislative “endorse” items are led by others and endorsed by the CFTF.

“Administrative” items are currently non-legislative action items sought to be further examined or advanced by the CFTF.

Note: Items with an asterisk (*) are those carrying over from the 2020 CFTF Action Agenda.
All items below are explained in detail with supporting evidence on page 13-51.

Recommendations to strengthen the statewide Child Fatality Prevention System to increase the system’s ability to prevent child abuse, neglect, and death

LEGISLATIVE:

- *Support legislation, agency action, and policy change to implement the following changes to the Child Fatality Prevention System (CFP System):
 - I. Implement centralized state-level staff with whole-system oversight in one location within the Department of Health and Human Services (DHHS) with the formation of a new cross-sector Fatality Review and Data Group and with child fatality staff in the Office of the Chief Medical Examiner (OCME) remaining in OCME.
 - II. Implement a centralized electronic data and information system that includes North Carolina joining 45 other states to participate in the National Child Death Review Case Reporting System.
 - III. Reduce the volume of team reviews by changing the types of deaths required to be reviewed by fatality review teams to be according to certain categories most likely to yield prevention opportunities.
 - IV. Reduce the number and types of teams performing fatality reviews by combining the functions of the four current types of teams into one with different procedures and required participants for different types of reviews (including intensive-type reviews of abuse or neglect-related deaths with state-level staff assistance), and giving teams the option to choose whether to be single or multi-county teams. DHHS should study and determine an effective framework for meeting the federal requirements for Citizen Review Panels and for reviewing active DSS cases without using all local review teams for these purposes.
 - V. Formalize the three committees of the Child Fatality Task Force (CFTF) with certain required committee members and expand the required CFTF report to address the whole CFP system with required report to be distributed to additional state leaders beyond the Governor and General Assembly.
- *Support for maintaining current state funding for existing positions and operations that support Child Fatality Prevention System work, and for additional recurring funding to support this work pursuant to DHHS determinations to be made related to the most appropriate placement and staffing configuration for this central office as well as funding needs of local health departments to support CFP system work.
- *Pursuant to DHHS determinations to be made related to launching a Fetal and Infant Mortality Review Program to inform state-level action related to the prevention of child deaths, support funding to enable implementation of the evidence-informed practice of FIMR as a pilot.

Recommendations to prevent youth suicide and firearm-related deaths and injuries to children

LEGISLATIVE:

- *Support state funding for a new statewide firearm safety initiative, as recommended by the 2017 Firearm Safety Stakeholder group, that is focused on education and awareness surrounding firearm safe storage and distribution of free gun locks; funding to go to DHHS to appropriately engage a third-party organization to implement the initiative. (Two-year funding estimate is for \$155,700: \$86,500 for year one; \$69,200 for year two.)
- Appropriate recurring funding to increase the number of school social workers, school nurses, school counselors, and school psychologists to support the physical and mental health of students and to move North Carolina toward achieving nationally recommended ratios for these professional positions in schools.

ADMINISTRATIVE:

- *Administrative support to explore and pursue possibilities for funding for a three-year lead suicide prevention coordinator position in North Carolina that would coordinate cross-agency efforts to carry out implementation of the 2015 NC Suicide Prevention Strategic Plan and determine a sustainability plan for ongoing statewide coordination for implementation of the Strategic Plan.
- Administrative support to follow implementation of new provisions in the NC Board of Education School Mental Health Policy that relate to strengthened school/community connections to address student mental health; information on implementation to be studied by the Intentional Death Prevention Committee prior to the 2022 legislative session.

Recommendations to prevent infant deaths

LEGISLATIVE:

- *Support a state appropriation of \$85,000 in additional funding to expand the Safe Sleep NC program that works to prevent sleep-related infant deaths.
- *Support legislative changes to strengthen North Carolina's Infant Safe Surrender law to make it more likely the law will be used in circumstances for which it was intended to protect a newborn infant at risk of abandonment or harm by making legislative

changes to accomplish the following:

1) remove "any adult" from those designated to accept a surrendered infant; 2) provide information to a surrendering parent; 3) strengthen protection of a surrendering parent's identity; 4) incorporate steps to help ensure the law is only applied when criteria are met. (This was an administrative item in 2020 and was a legislative item in prior years)

- *Endorse additional QuitlineNC funding of \$3 million [to prevent perinatal tobacco use].



Recommendations on workplace supports to strengthen child and family health, well-being, and economic stability

LEGISLATIVE:

- *Endorse passage of a kin care and safe days bill that would guarantee all North Carolina workers the right to use their sick days (whether paid or job-protected unpaid) to care for a sick loved one, seek preventative care, or deal with the physical,

mental, or legal impacts of domestic violence, sexual assault, or stalking.

- *Endorse legislation that would guarantee all North Carolina workers the right to reasonable pregnancy and lactation accommodations in the workplace.

Recommendations to strengthen education and awareness around child abuse and neglect reporting

LEGISLATIVE:

- Legislation that would add child abuse and neglect reporting requirements to the topic list for required mental health training for school personnel in Session Law 2020-7.

ADMINISTRATIVE:

- Administrative support for continued efforts to strengthen education and awareness surrounding child abuse and neglect reporting, including strengthening ongoing training for law enforcement that also supports an understanding of trauma and mental health; and training that is tailored for healthcare providers.

Recommendations and administrative efforts to prevent motor vehicle-related injuries and deaths to children

LEGISLATIVE:

- *Support legislation that would require ignition interlocks for all DWI offenders.

ADMINISTRATIVE:

- *Administrative support to continue efforts to gather information on the potential for future legislation that allows for primary enforcement of all unrestrained back seat passengers with the intent to bring this item back for consideration by the Unintentional Death Prevention

Committee prior to the 2022 legislative session, and Governor's Highway Safety Program to work with the Driver Education Advisory Committee to educate about the importance of back seat restraints.

- Administrative support for continuation of a child passenger safety study by the Occupant Protection Task Force to bring information back to the Unintentional Death Prevention Committee for consideration prior to the 2022 legislative session.

Recommendation to prevent harm to youth caused by tobacco and nicotine use

LEGISLATIVE:

- *Endorse at least \$7 million in funding for youth nicotine use prevention, including e-cigarettes.



Explanation of **CFTF 2021 Action Agenda**

Recommendations to strengthen the statewide Child Fatality Prevention System to increase the system's ability to prevent child abuse, neglect, and death

The NC Child Fatality Task Force was originally created in 1991 as part of a new statewide Child Fatality Prevention System. One of the original statutory duties of the Task Force, which remains in the statute, is to “develop a system for multidisciplinary review of child deaths.” It is therefore important to recognize that these particular recommendations, being repeated from 2019 and 2020, are rooted in the responsibility the Task Force has to the functioning of the statewide Child Fatality Prevention System. In 2017, the Executive Committee of the Task Force recognized that the Task Force had a responsibility to look at the system as a whole, and in 2018 the Task Force began to do so for the first time since its creation. As is explained below, many stakeholders and experts have been involved in developing recommendations and plans for a restructured and strengthened Child Fatality Prevention System. Without

legislative action that includes changes in law and new funding, however, that restructuring and strengthening is not possible.

The North Carolina Child Fatality Prevention System (CFP System) is large and complex. It was created in 1991 by state statute and consists of local child fatality review teams in every county (Child Fatality Prevention Teams and Community Child Protection Teams, collectively called “Local Teams”); a state Child Fatality Prevention Team (State Team) led by the Chief Medical Examiner; and the Child Fatality Task Force (Task Force), a legislative study commission that makes policy recommendations and does not conduct child fatality reviews.¹ There is also a State Child Fatality Review Team that reviews certain child maltreatment-related fatalities and utilizes members from Local Teams, but it is addressed in a statute that is separate from the rest of the CFP System.²

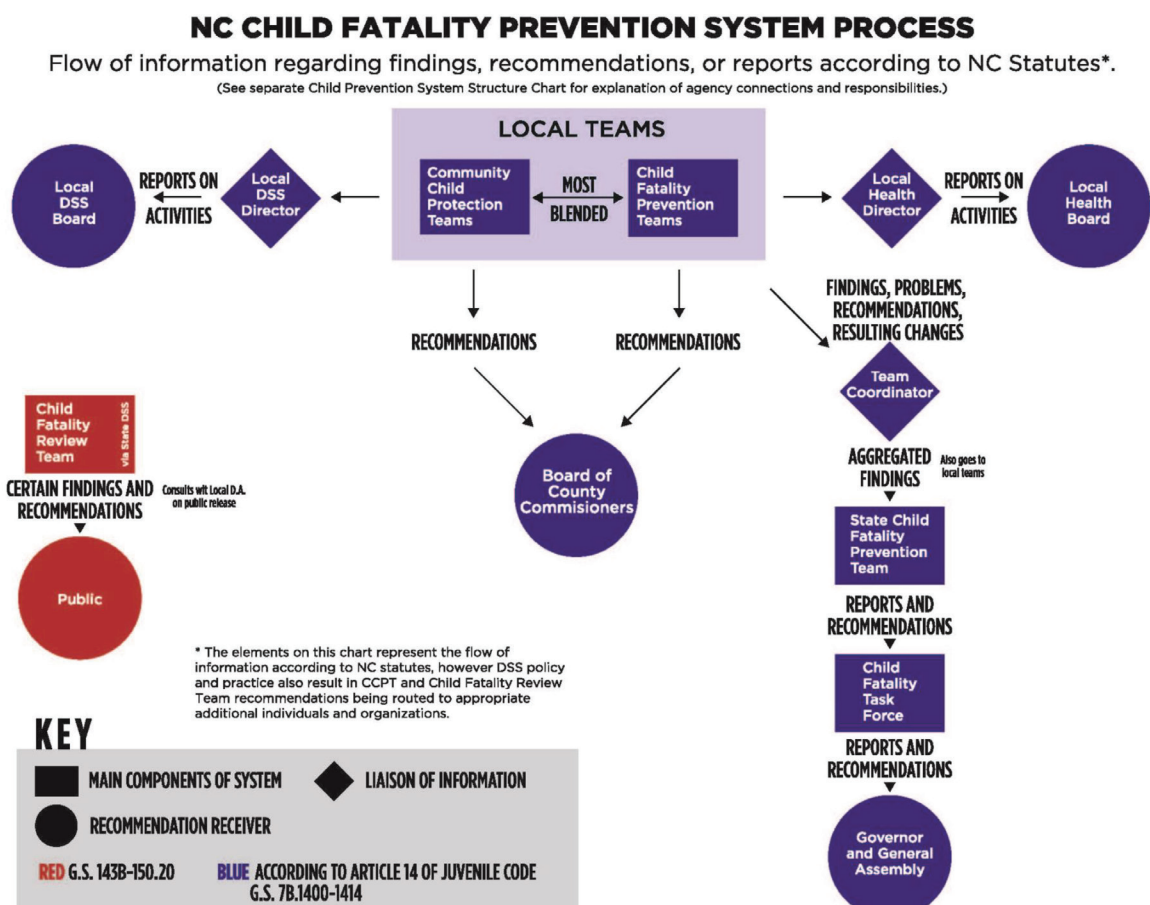
¹ N.C.G.S. 7B-1400 - 1414.

² N.C.G.S. 143B-150.20.

designed to prevent child maltreatment and death. A primary purpose of the CFP System is to make and implement recommendations for laws, rules, and policies that will support the safe and healthy development of children and prevent future child fatalities and maltreatment.

Recommendations stemming from state and local review teams and the Task Force are directed to various entities ranging from boards of county commissioners, local and state-level social services leaders, to the Governor and the General Assembly. In addition, the CFP System is structured for certain information and recommendations to be passed among review teams and the Task Force.

HERE IS A GRAPHIC ILLUSTRATION OF THE FLOW OF INFORMATION WITHIN THE CURRENT CFP SYSTEM ACCORDING TO STATUTES:



As these two graphics illustrate, the system has many people, parts, and information that are in some ways connected and in other ways disconnected. The fact that the system is complex and has disconnected components makes it challenging even for those working within the system to understand its many moving parts and to coordinate with other parts of the system.

Since 2018, the Child Fatality Task Force has been examining ways to strengthen the Child Fatality Prevention System and these efforts have included input from stakeholders across the state as well as national experts in child fatality review and prevention. This included a statewide Child Fatality Prevention System Summit in the spring of 2018 that brought together over 200 system participants, state and national experts and leaders to learn

about best practice and address challenges and strengths of the system. (More detail about this work is available in the 2018 and 2019 CFTF Annual Reports.) For its 2019 Action Agenda, the Task Force included a set of recommendations aimed at strengthening the Child Fatality Prevention System, and although there were no new laws addressing these recommendations in 2019, these recommendations have partially advanced. These recommendations were addressed in the 2019 legislative session in House Bill 825, and the language from that bill was then included in the 2019 Appropriations Act, House Bill 966, which did not become law. These recommendations of the Task Force were also adopted in the Child Welfare Reform Plan Final Report from the Center for the Support of Families.⁴

⁴ Center for the Support of Families (May 6, 2019). *Child Welfare Reform Plan Final Report*. State of North Carolina Office of State Budget and Management (OSBM) with Department of Health and Human Services (DHHS) https://files.nc.gov/ncosbm/documents/files/ChildWelfareReform_FinalPlan.pdf.



In addition, the NC Department of Health and Human Services has already undertaken further study and planning related to advancing these recommendations, as the recommendations are aligned with current DHHS priorities and the statewide Early Childhood Action Plan. This work by DHHS, presented to the Task Force in 2020 and 2021, has included formation of a DHHS work group to discuss goals and structure of a new state office of child fatality prevention, interviews with other states related to their fatality review systems and Citizen Review Panels, and consultation with national experts. DHHS also partnered with the North Carolina Institute of Medicine to convene stakeholders from across the state whose local or state-level work overlaps with the Child Fatality Prevention System to get their input on various aspects of restructuring implementation.

For the 2021 Action Agenda, the Child Fatality Task Force is now repeating the recommendations made in both 2019 and 2020. These recommendations are aimed at strengthening the overall Child Fatality Prevention System with the ultimate goal of preventing child deaths and maltreatment and supporting child safety and wellbeing.

Outcomes we want to achieve FOR KIDS:

- Ensure that the prevention of child fatalities and maltreatment is approached as a community-wide and state-wide responsibility.
- Identify and address system problems or gaps in order to prevent future fatalities & maltreatment.
- Accurately collect and analyze child death data for the purpose of better understanding the apparent and contributing causes of child death and opportunities to prevent future deaths.
- Identify effective strategies for the prevention of child fatalities and maltreatment.
- Implement effective local and state-level strategies (in the form of programs or changes in law or policy) for the prevention of child fatalities and maltreatment.
- Leverage the collaboration and expertise of multidisciplinary teams to draw on public and private resources at the state and local level to accomplish all of the above outcomes in order to prevent future child abuse, neglect, and death.

Structural outcomes these changes seek to address:

- Eliminate the “silos” within which current system functions.
- Implement centralized coordination/oversight.
- Streamline state-level support functions of CFP System & add capacity to elevate the effectiveness of all system components.
- Eliminate the redundancy/duplication of team reviews but keep critical functions & diverse contributions of expertise.
- Ensure that review teams have the training and resources they need to conduct effective reviews and make effective recommendations.
- Maximize the usefulness of data/information learned from reviews by expanding, improving, and standardizing data capture, analysis, and reporting.
- Ensure that relevant & appropriate information & recommendations from team reviews reaches local leaders, state agency leaders, and the CTF in a timely fashion.
- Ensure that CTF’s ability to study data, evaluate evidence, and advance policies continues.

LEGISLATIVE RECOMMENDATION #1:

Support legislation, agency action, and policy change to implement the following changes to the Child Fatality Prevention System (CFP System):

- I. Implement centralized state-level staff with whole-system oversight in one location within the Department of Health and Human Services with the formation of a new cross-sector Fatality Review and Data Group and with child fatality staff in the Office of the Chief Medical Examiner remaining in OCME.

The current system has no lead organizational unit or individual. Individuals who are in state-level roles supporting the current system work in separate “silos” within a structure that is not conducive to interaction or coordination with one another, even though some of their functions overlap. Having a centralized state-level staff connects the CFP System components, streamlining state-level support functions to enable increased efficiency and capacity while also promoting the standardization of tools and resources for all local review teams. A new cross-sector Fatality Review and Data Group would serve as a liaison of information among local teams, OCME, and the Task Force and could be structured to do occasional state-level reviews of cases, if needed. Child fatality staff with the OCME would remain in the OCME and continue to review all child fatality medical examiner cases.

- II. Implement a centralized electronic data and information system that includes North Carolina joining 45 other states to participate in the National Child Death Review Case Reporting System.

Under the current system structure, there are gaps and complexities with information collection, analysis, sharing and reporting that need to be addressed. The use of one electronic national data system that is free and already used by 45 other states would modernize and standardize data collection. It would also

promote gathering richer layers of data than what is currently collected by most types of review teams, which will lead to a strengthened ability to inform prevention initiatives and policy change.

- III. Reduce the volume of team reviews by changing the types of deaths required to be reviewed by fatality review teams to be according to certain categories most likely to yield prevention opportunities.

North Carolina is the ninth most populated state and had 1,255 child deaths in 2018 (ages 0 to 17) and 1265 child deaths in 2019. Reducing the number of deaths required to be reviewed by teams to those categories most likely to yield identification of system problems and/or prevention opportunities allows for optimization of CFP efforts system-wide. In particular, a goal is that in reducing the volume of reviews, the reviews of infant deaths, which make up two-thirds of all child deaths, can be strengthened. Current recommendations are to require team reviews of the following categories of deaths: undetermined, unintentional injury, violence, motor vehicle, child abuse or neglect/CPS involvement, sudden unexpected infant deaths (SUIDs), suicide, deaths not expected in next six months, and additional infant deaths (criteria to be determined by DHHS).

- IV. Reduce the number and types of teams performing fatality reviews by combining the functions of the four current types of teams into one with different procedures and required participants for different types of reviews (including intensive-type reviews of abuse or neglect-related deaths with state-level staff assistance), and giving teams the option to choose whether to be single or multi-county teams. DHHS should study and determine an effective framework for meeting the

federal requirements for Citizen Review Panels and for reviewing active DSS cases without using all local review teams for these purposes.

The current North Carolina system has four different types of review teams — two at the local level and two at the state level — plus the NC Child Fatality Task Force, which does not conduct reviews but is the policy arm of the system. This structure results in duplication with different teams routinely reviewing the same case. This recommendation removes duplication of efforts, with the goal of getting all of the very best local and state-level information available for one case in front of a local team for one effective review. An important aspect of this recommendation is the need to structure team reviews so the procedures and required participants as well as the degree of technical assistance provided by the state can be adjusted to most effectively address the *type* of death being reviewed, such as deaths related to abuse or neglect which can still receive the type of in-depth review that is done under the current system.

- V. Formalize the three committees of the Child Fatality Task Force (CFTF) with certain required committee members and expand the required CFTF report to address the whole CFP system with required report to be distributed to additional state leaders beyond the Governor and General Assembly.

The Child Fatality Task Force has for much of its 30-year existence found successful functioning by structuring its work through three committees: Perinatal Health, Unintentional Death Prevention, and Intentional Death Prevention. More formally defining these committees and requiring certain committee members ensures consistent expert and agency input and member attendance in committee meetings. With the above recommendations, components of the system would be more connected — so it would be appropriate and meaningful for this annual Task Force report to address not only the work of the CFTF but the work of the system as a whole and for the report to be submitted to additional state leaders.

LEGISLATIVE RECOMMENDATION #2:

Support for maintaining current state funding for existing positions and operations that support Child Fatality Prevention System work, and for additional recurring funding to support this work pursuant to DHHS determinations to be made related to the most appropriate placement and staffing configuration for this central office as well as funding needs of local health departments to support CFP system work.

The new system structure being recommended by the Child Fatality Task Force will only work if there is a newly created state office of child fatality prevention to support the new structure. This new state office will have certain positions and areas of work that do not currently exist within the system and

will therefore require some funding. Local teams are comprised of community leaders whose collaborative efforts have the potential to launch powerful prevention initiatives, however their ability to be engines of positive change in their communities depends on resources for implementation.

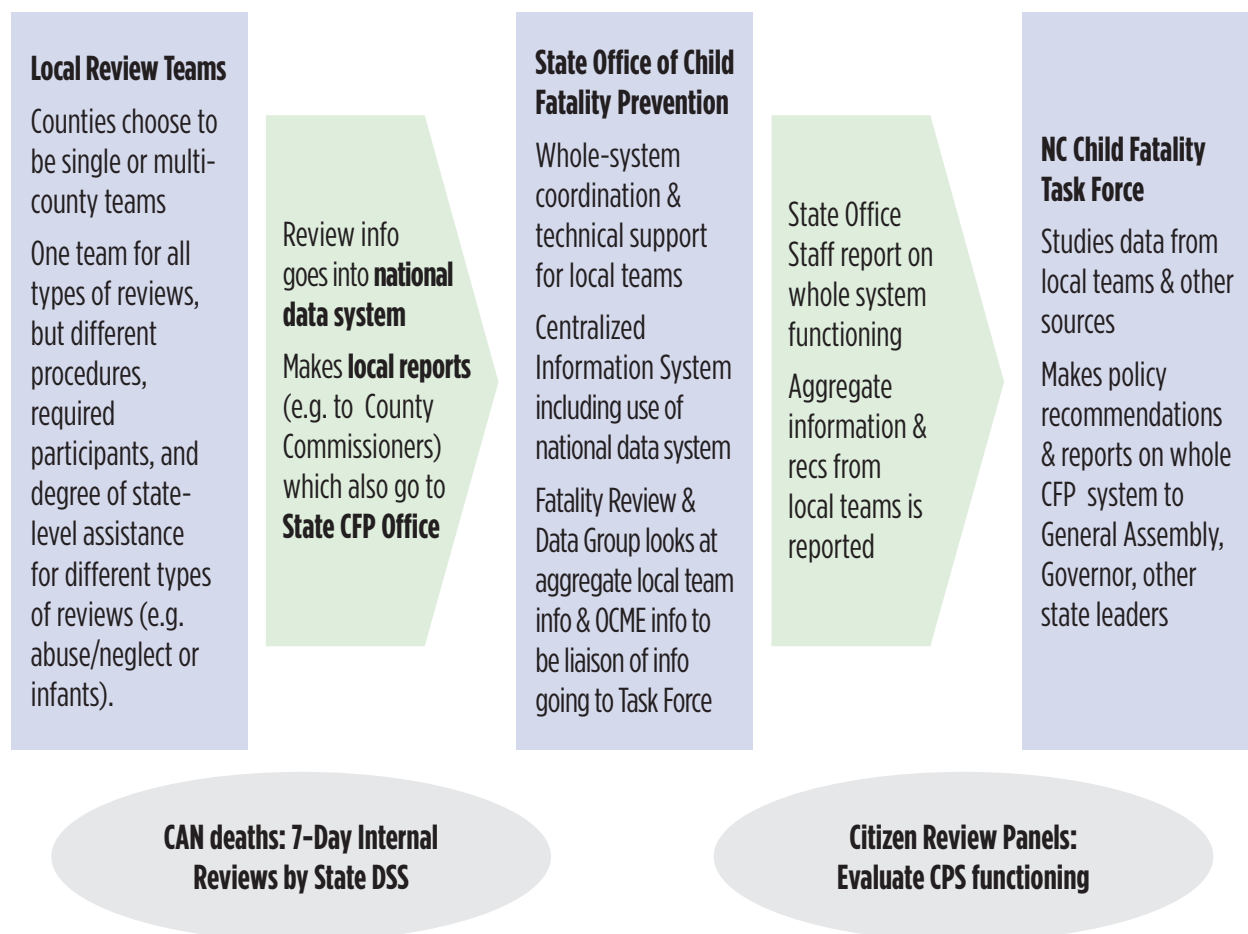
LEGISLATIVE RECOMMENDATION #3:

Pursuant to DHHS determinations to be made related to launching a Fetal and Infant Mortality Review (FIMR) Program to inform state-level action related to the prevention of infant deaths, support funding to enable implementation of the evidence-informed practice of FIMR as a pilot.

FIMR programs utilize a specialized model of fatality review. Although more than half of states have FIMR programs (there are around 175 programs nationwide), North Carolina does not. FIMR utilizes different procedures and participants that require a great deal more staff support with specialized expertise, and therefore more resources, than what is required for typical child death reviews. The FIMR process uses trained health care experts to gather, analyze, and synthesize case information from various sources, especially health care records, and utilizes trained professionals (which can be

the same or a different person) to conduct in-person interviews with the mother and/or family of the child. The in-person interview is considered to be a very valuable aspect of the process that distinguishes it from other types of reviews. Information collected is prepared by staff and brought to the review in a de-identified format. Because the degree of resources required to implement FIMR is higher than for typical reviews, it would not be feasible to implement FIMR on a statewide basis, but implementation in some communities could be valuable to inform both local and state-level actions for prevention.

NEW MODEL STRENGTHENS TEAM REVIEWS, DATA, STATE-LEVEL SUPPORT, REPORTING

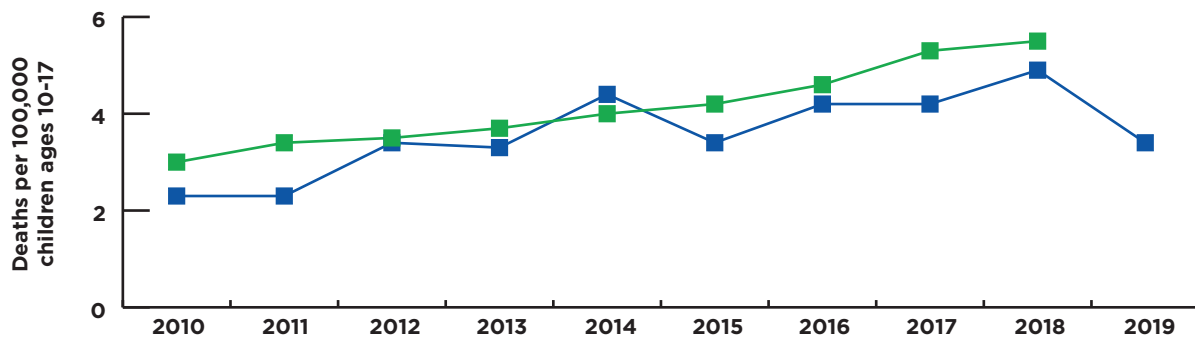


Recommendations to prevent youth suicide and firearm-related deaths and injuries to children

In 2018, the rates for youth suicide and firearm-related deaths to children and youth in North Carolina were the highest seen by the Child Fatality Task Force. In 2018, suicide was the leading cause of death for North Carolina youth ages 15 to 17 and the second leading cause of death for youth ages 10 to 14.

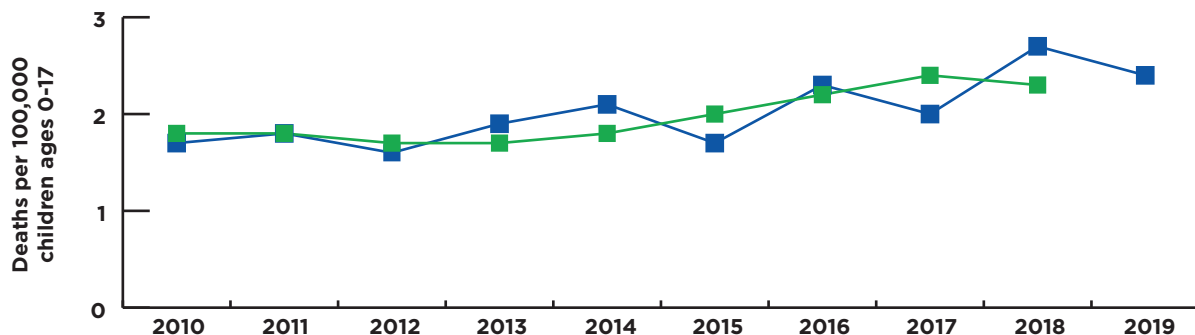
Although the 2019 youth suicide rates were not as high as 2018, in 2019 suicide was the third leading cause of death for ages 15 to 17 and the second leading cause for ages 10 to 14.⁵ In North Carolina, firearms are the lethal means used in almost half of youth suicides and more than half of youth homicides.

SUICIDE RATES, AGES 10 TO 17: NC 2010-2019



Source: NC State Center for Health Statistics & National Center for Health Statistics

FIREARM-RELATED MORTALITY RATES*, CHILDREN AGES 0 TO 17: NC & US, 2010-2019



Source: NC State Center for Health Statistics & National Center for Health Statistics

* Firearm deaths included the following ICD-codes: Unintentional W32-W34; Suicide X72-X74; Homicide X93-X95, U014, Undetermined Y22-Y24

⁵ Source for data: Child Deaths in North Carolina, Annual Reports for 2018 and 2019, produced by the NCDHHS Division of Public Health – Women's and Children's Health Section in conjunction with the State Center for Health Statistics.

The connections: firearm safety, youth suicide, and school safety

- Firearms are the lethal means used in almost half of youth suicides in NC.
- Access to firearms is a known risk factor for suicide.
- Many suicide attempts are hastily decided upon during a short-term crisis, with only minutes of deliberation prior to an attempt.
- Firearms have a fatality rate of over 82%, which is much higher than other common methods of suicide.
- National studies show that most kids know where parents keep their guns and that more than 75% of guns used in suicide attempts and unintentional injuries of kids were stored in the home of the victim, a relative, or a friend.
- Studies show that guns used in American mass school shootings usually come from family.

The two legislative recommendations being made by the Task Force this year that relate to suicide and firearm safety both have their roots in recommendations made to the Task Force by the State Child Fatality Prevention Team (“State Team”), which reviews individual cases of child fatalities. Out of concerns with youth suicide, the State Team has for several years recommended that the Task Force focus efforts on firearm safe storage education and awareness and programs addressing access to lethal means. The State Team has also recommended increasing the number of school nurses, social workers, psychologists, and counselors to meet nationally recommended ratios. This recommendation was prompted by the State Team’s recognition of the need for greater mental health supports for students in schools.



LEGISLATIVE RECOMMENDATION:

Support state funding for a new statewide firearm safety initiative, as recommended by the 2017 Firearm Safety Stakeholder group, that is focused on education and awareness surrounding firearm safe storage and distribution of free gun locks; funding to go to DHHS to appropriately engage a third-party organization to implement the initiative. (Two-year funding estimate is for \$155,700: \$86,500 for year one; \$69,200 for year two.)

In the most recent 10-year period of 2010–2019, North Carolina lost more than 460 children and youth (age 17 and younger) to firearm-related injuries.⁶ In the four-year period from 2016–2019, there were 437 firearm-related hospitalizations and 1,246 firearm-related emergency department visits for children and youth in North Carolina age 0 to 17.⁷

National data and studies tell us this: more than half of all gun owners store at least one gun unsafely;⁸ most kids know where parents keep their guns;⁹ more than 75% of guns used in suicide attempts and unintentional injuries of kids were stored in the home of the victim, a relative, or a friend;¹⁰ and guns used in American mass school shootings often come from home.¹¹

**460+ children in NC
age 17 and younger died**
due to firearm-related injuries between 2010 and 2019

**More than half of
all gun owners**
store at least one gun unsafely, and most
children know where parents keep their guns.



⁶ Data source: Office of the Chief Medical Examiner, NC Division of Public Health.

⁷ NC State Center for Health Statistics, Hospital Discharge Data (2016 – 2019); NC DETECT (2016 –2019). Analyses by: Injury and Violence Prevention Branch (IVPB), Epidemiology, Division of Public Health. (Data from prior to 2016 are not comparable due to the ICD-10-CM coding transition and changes in surveillance methodology.)

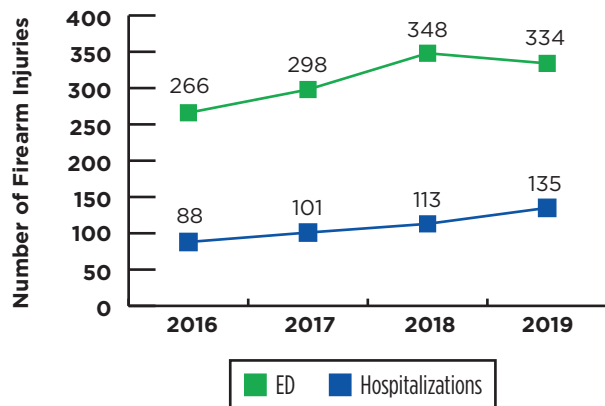
⁸ Crifasi, Cassandra K., et al., Storage Practices of US Gun Owners in 2016, *American Journal of Public Health* 108, no. 4 (2018). In this study, safe storage practices included storage in a locked gun safe, cabinet or case; locked into a gun rack; or stored with a trigger lock or other lock.

⁹ 73% of children under age 10 living in homes with guns reported knowing the location of their parents' firearms. Baxley F, Miller M. Parental Misperceptions About Children and Firearms. *Arch Pediatr Adolesc Med*. 2006;160(5):542–547. doi:10.1001/archpedi.160.5.542.

¹⁰ Grossman DC, Reay DT, Baker SA. Self-inflicted and Unintentional Firearm Injuries Among Children and Adolescents: The Source of the Firearm. *Arch Pediatr Adolesc Med*. 1999;153(8):875–878. doi:10.1001/archpedi.153.8.875.

¹¹ Giffords Law Center to Prevent Gun Violence: “A report published by the US Secret Service and the Dept. of Education found that in 65% of school shootings covered by the study, the shooter used a gun obtained from his or her own home or from the home of a relative.” Report: “The Final Report and Findings of the Safe School Initiative – Implications for the Prevention of School Attacks in the United States.” (July 2004). In addition, A Wall Street Journal report in April of 2018 examining nearly three decades of American mass school shootings stated that the killers in these shootings mostly used guns owned by a family member; the report addressed the big role that a lack of gun safety at home has played in school shootings. [Hobbs, Tawnell D. (April 5, 2018). “Most Guns Used in School Shootings Come From Home,” *Wall Street Journal*.]

FIREARM-RELATED EMERGENCY DEPARTMENT (ED) VISITS AND HOSPITALIZATIONS AMONG CHILDREN (0-17) IN NC*



*Limited to NC Residents

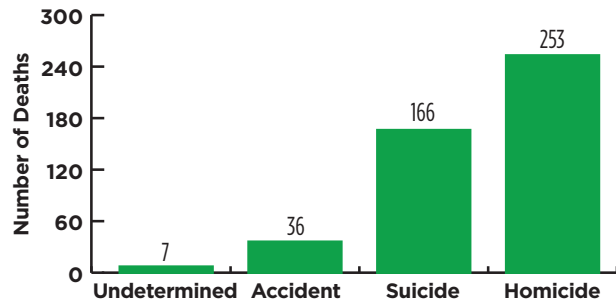
Source: NC State Center for Health Statistics, Hospital Discharge Data (2016-2019); NC DETECT (2016-2019)

Recommendation informed by diverse Firearm Safety Stakeholder Group

This recommendation to launch and fund a statewide firearm safe storage initiative was informed by a group of diverse stakeholders who met in 2017 for the purpose of discussing solutions related to firearm safety education in North Carolina. Firearm Safety Stakeholder Group (FSSG) members, educators, and conveners represented diverse organizations and areas of expertise including:

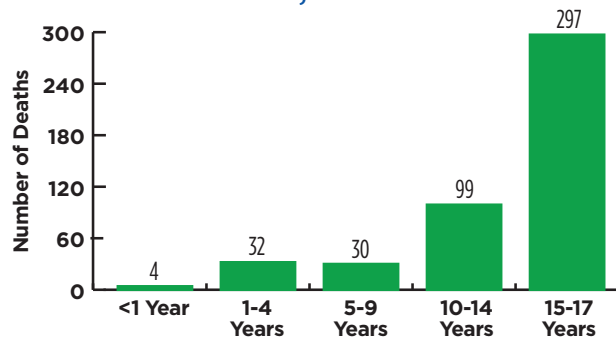
- City Police Chief
- Department of Public Instruction
- Durham Gun Team
- Hunter educator
- Injury & Violence Prevention Branch, Division of Public Health
- Juvenile Justice Health Services
- National Rifle Association
- NC Child Fatality Prevention Team
- NC Child Fatality Task Force
- NC Coalition Against Domestic Violence
- NC Department of Justice
- NC Wildlife Officer
- North Carolinians Against Gun Violence
- Pediatrician with expertise in child safety
- Safe Kids NC
- UNC Injury Prevention Research Center
- Academic researcher

YOUTH FIREARM DEATHS IN NORTH CAROLINA BY MANNER, FROM 2010-2019



Source: North Carolina Office of the Chief Medical Examiner

YOUTH FIREARM DEATHS IN NORTH CAROLINA BY AGE GROUP, FROM 2010-2019



Source: North Carolina Office of the Chief Medical Examiner

The FSSG reviewed firearm-related data, existing state and national firearm safety education and awareness campaigns and available evaluations of their effectiveness, and best practices for communications campaigns. Members of the group also shared their own knowledge and perspectives with one another in small and large group discussions.

The FSSG identified the type of safety initiative needed in North Carolina to be one that prioritizes educating all gun owners and distributing gun locks, and should include the following components:

- State-level development of a website where NC citizens can go for information about firearm safety and protecting children and youth from firearm-related deaths and injuries.
- State-level development of a firearm safety toolkit to assist communities with launching local firearm safety initiatives.

The stakeholder group informing this initiative determined that local community mobilization initiatives have the best chance of effectively educating people and getting them to engage in safe storage practices. The majority of funding for this initiative will go toward providing state-level outreach and technical assistance to local communities across the state to help them launch local initiatives tailored to their community's needs.

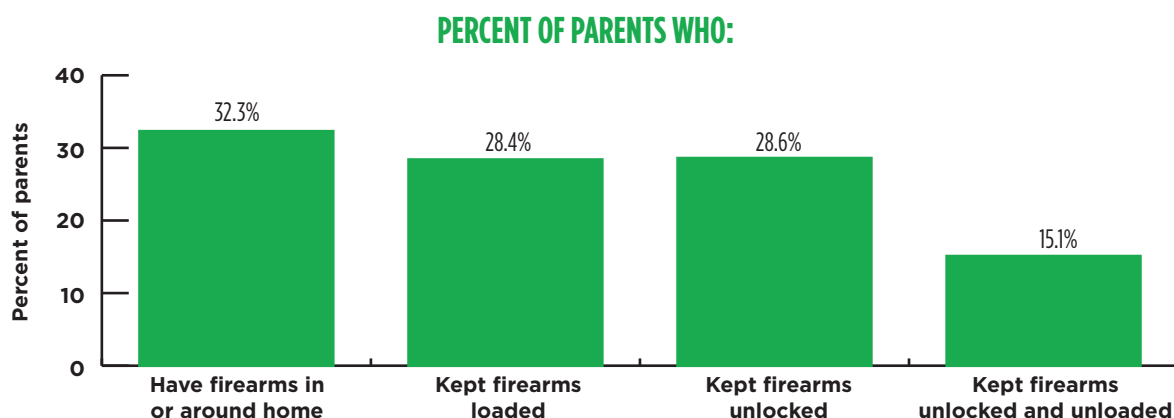
- State-coordinated outreach to local communities to distribute toolkits (and gun locks) and help them launch local initiatives.
- State funding to support all of the above including the purchase and distribution of gun locks.

In reviewing evidence about initiatives most likely to be effective, the FSSG determined that local community mobilization initiatives had the best chance of effectively educating people and getting them to engage in safe storage practices. The group also emphasized the need to provide firearm safety information, resources, and tools at the state level, but getting people to use those resources and tools is what will increase safety. The Unintentional Death Prevention Committee estimated that the majority of funding needed for this initiative was to engage a qualified organization (or individuals) to lead this work and, in particular, to provide outreach and technical assistance to local communities across the state to help them launch local initiatives tailored to their community's needs.

Previous Bipartisan Support for Initiative

Proposed legislation in 2019 addressed this 2019 Task Force recommendation to launch and fund a firearm safety initiative. Introduced in March of 2019 as House Bill 508, the bill had bipartisan support and was then included in House Bill 966, the 2019 Appropriations Act, which never became law. In August of 2019, North Carolina Governor Roy Cooper signed a gun safety Executive Directive containing a number of required actions aimed at promoting firearm safety and preventing firearm violence. This directive set in motion the development and compilation of firearm safety tools and resources by the Division of Public Health, using elements of the firearm safety stakeholder group's recommendations to inform this work. While a webpage on the Division of Public Health website now provides information on firearm safety, without funding from the legislature, there are no resources for the type of initiative recommended by the Task Force that provides dedicated, one-on-one outreach and technical assistance that will be needed to get communities across the state launching local firearm safety initiatives tailored to their communities.

GUN SAFETY, NC CHAMP (AGES 0-17), 2016-2017



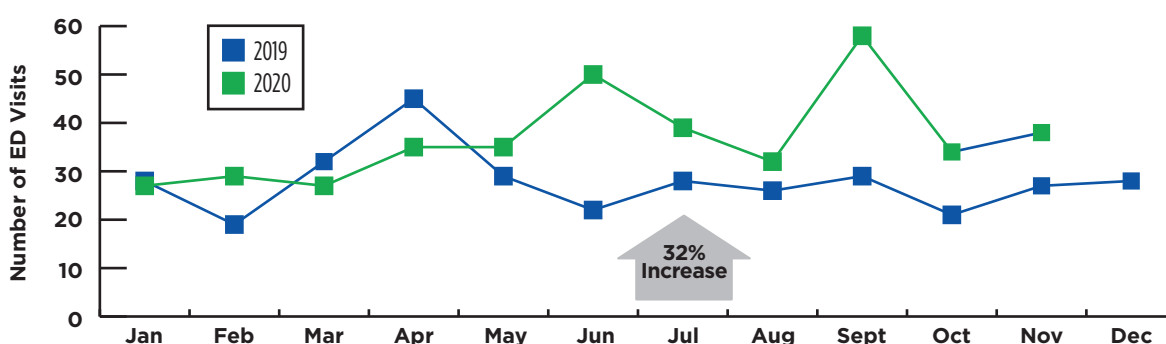
Source: NC Child Health Assessment and Monitoring Program (NC CHAMP), 2016-2017 • Analysis by Injury Epidemiology and Surveillance Unit.

Pandemic impact: Significant increase in gun sales elevates gun safety concerns

Presenters on this issue during the 2020-2021 study cycle also shared data about the dramatic increase in gun sales during the pandemic. There is no system for tracking gun sales, however the number of firearm background checks conducted by the FBI is considered to be a loose proxy for gun sales and in 2020, these checks rose to an all-time high.¹² North Carolina data on the number of concealed carry handgun

orders for certificates and certificates issued to instructors through August 2020, shared with the Unintentional Death Prevention Committee, also showed a significant increase compared to recent years.¹³ More guns in communities logically means there are more unsecured guns accessible to curious children or youth at risk of suicide or violence. The data for emergency department visits for firearm-related injuries for children 17 and younger in North Carolina shows a 32% increase for 2020 compared to 2019.

ED VISITS DUE TO FIREARM-RELATED INJURIES AMONG CHILDREN 17 AND YOUNGER



Note: Limited to NC Residents; 2020 Provisional Data as of 1/13/2021 • Source: NC DETECT ED Visits, 2019-2020 • Analysis by Injury Epidemiology and Surveillance Unit

LEGISLATIVE RECOMMENDATION:

Appropriate recurring funding to increase the number of school social workers, school nurses, school counselors, and school psychologists to support the physical and mental health of students and to move North Carolina toward achieving nationally recommended ratios for these professional positions in schools.

For the past several years, the Intentional Death Prevention Committee has discussed the important role that schools and school personnel play in helping to prevent youth suicide. The committee and the CFTF have made recommendations related to that role, some of which have advanced.¹⁴ During recent meetings, this committee reviewed data that paints a concerning picture regarding the mental health status

and suicidal behaviors of students as well as the insufficient numbers of school support professionals to help meet their needs.

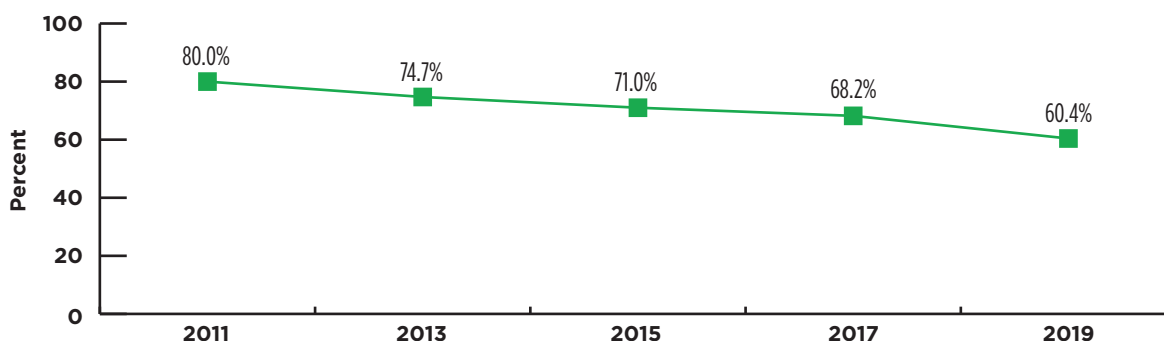
Presentations by school professionals were made to the Intentional Death Prevention Committee and to the full Task Force about the important connection between the mental and physical health of students and their ability to learn.

¹² The Economist. (January, 2021). *FBI Background Checks, a Proxy for Gun Sales, Surged in 2020*. www.economist.com/graphic-detail/2021/01/14/fbi-background-checks-a-proxy-for-gun-sales-surged-in-2020.

¹³ Concealed carry handgun orders for certificates and the number of certificates requested in each order has had large increases during some 2020 months compared to prior two years: total orders in 2020 for 8 months was 1,969 compared to total orders for 12 months in 2019 at 1,754 and 2018 at 1,458 (source: NCDOJ). The number of concealed carry certificates issued to instructors through August 2020 (8 months) = 122,998; for 2019 (12 months) = 84,375 (source: NCDOJ).

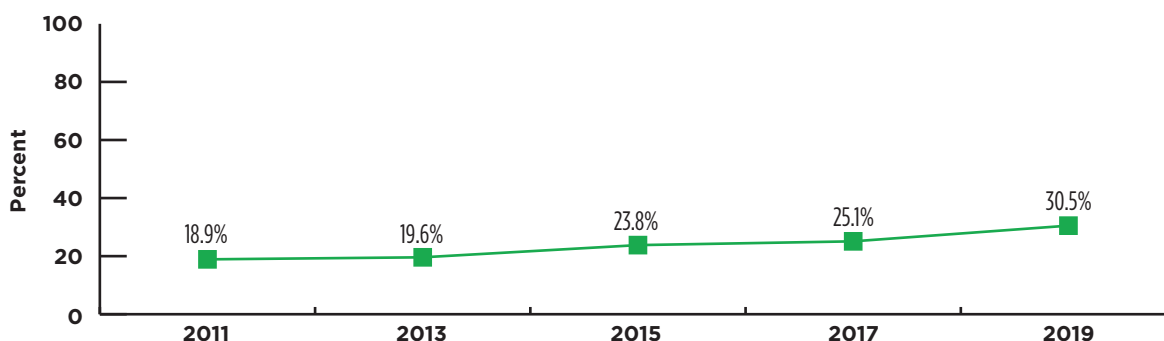
¹⁴ A CFTF recommendation to require suicide prevention training for school personnel and a risk referral protocol in schools was included in a larger student mental health training bill that became law as S.L. 2020-7. The CFTF also recommended increased funding for more school nurses, who spend one-third of their time addressing student mental health, and there has been some increased funding in recent years.

PERCENTAGE OF HIGH SCHOOL STUDENTS WHO STRONGLY AGREE OR AGREE THAT THEY FEEL GOOD ABOUT THEMSELVES



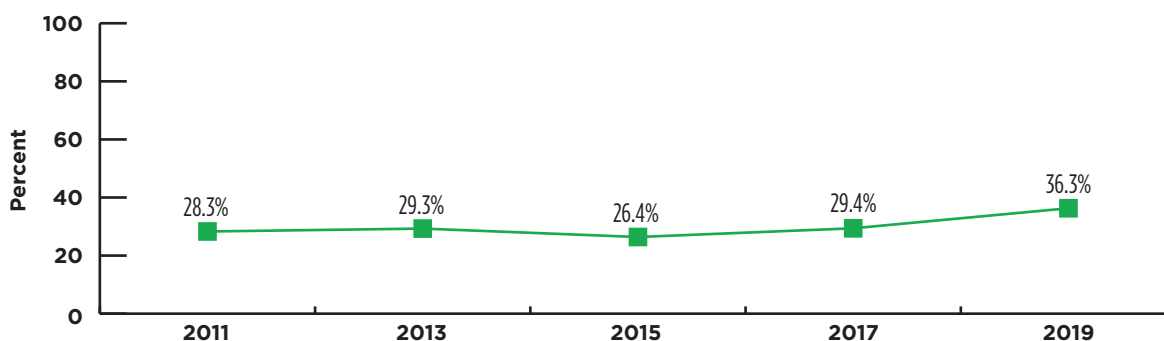
*Decreased 2007-2019, increased 2007-2011, decreased 2011-2019 [Based on linear and quadratic trend analyses using logistic regression models controlling for sex, race/ethnicity, and grade ($p < 0.05$). Significant linear trends (if present) across all available years are described first followed by linear changes in each segment of significant quadratic trends (if present).] • This graph contains weighted results. • Source: North Carolina - YRBS, 2011-2019 - QN113

PERCENTAGE OF HIGH SCHOOL STUDENTS WHO AGREE OR STRONGLY AGREE THAT THEY FEEL ALONE IN THEIR LIFE



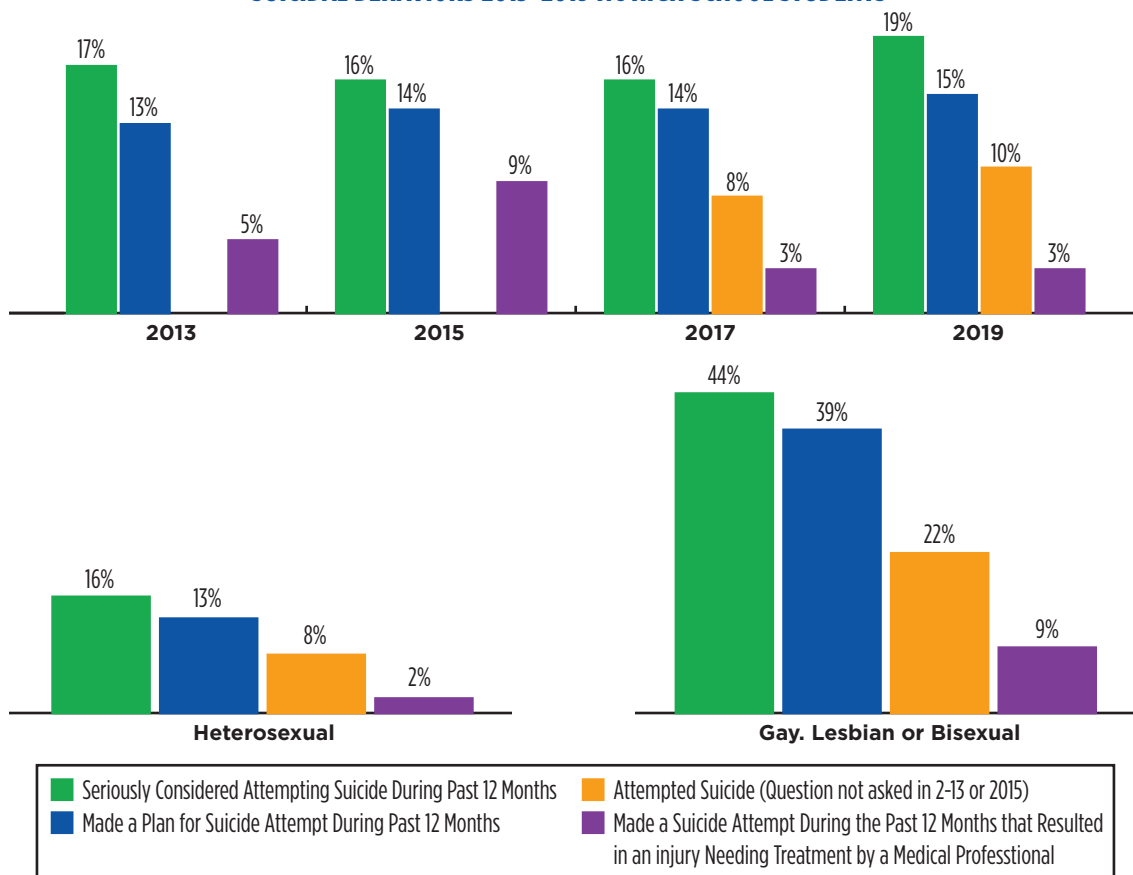
*Increased 2007-2019, decreased 2007-2011, increased 2011-2019 [Based on linear and quadratic trend analyses using logistic regression models controlling for sex, race/ethnicity, and grade ($p < 0.05$). Significant linear trends (if present) across all available years are described first followed by linear changes in each segment of significant quadratic trends (if present).] • This graph contains weighted results. • Source: North Carolina - YRBS, 2011-2019 - QN115

PERCENTAGE OF HIGH SCHOOL STUDENTS WHO FELT SAD OR HOPELESS



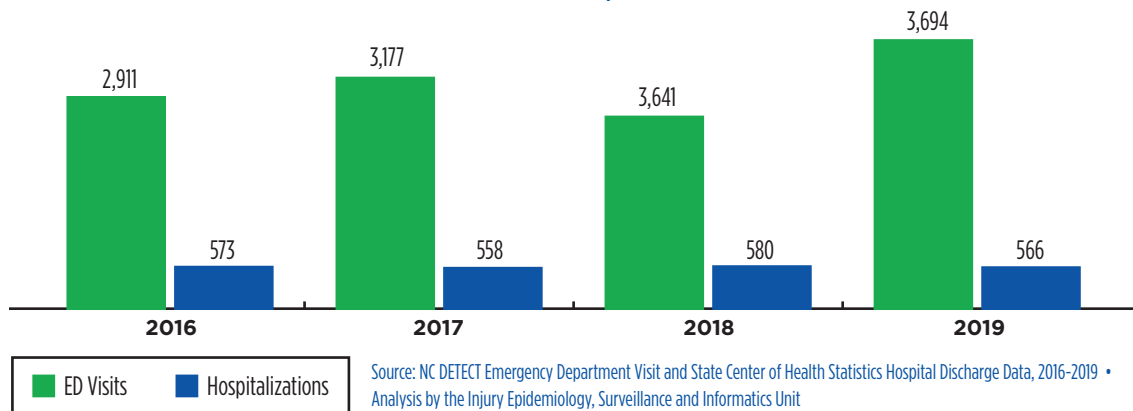
*Almost every day for ≥ 2 weeks in a row so that they stopped doing some usual activities, ever during the 12 months before the survey • *Increased 2001-2019, no change 2001-2015, increased 2015-2019 [Based on linear and quadratic trend analyses using logistic regression models controlling for sex, race/ethnicity, and grade ($p < 0.05$). Significant linear trends (if present) across all available years are described first followed by linear changes in each segment of significant quadratic trends (if present).] • This graph contains weighted results. • Source: North Carolina - YRBS, 2011-2019

SUICIDAL BEHAVIORS 2013-2019 NC HIGH SCHOOL STUDENTS*



Source: NC High School Youth Risk Behavior Survey

SELF-HARM/SELF-INFLICTED INJURY RELATED HOSPITALIZATIONS AND EMERGENCY DEPARTMENT VISITS, NC RESIDENTS AGES 10-18



Source: NC DETECT Emergency Department Visit and State Center of Health Statistics Hospital Discharge Data, 2016-2019 • Analysis by the Injury Epidemiology, Surveillance and Informatics Unit

School professionals explained the critical role played by the team of four comprised of a school social worker, nurse, counselor and psychologist and how the school's ability to meet the needs of their students is dependent on the strength of this team. In North Carolina, however, ratios of the numbers of these school professionals to numbers of students fall far short of meeting nationally recommended ratios, which means that in many places in our state, these teams are stretched too thin to effectively meet the needs of students. Below, the State Child Fatality Prevention Team also recognized the important role that these professionals play and they recommended to the Task Force increasing the numbers of these professionals.

Pandemic impact: Increased concern about youth mental health

Data graphics on earlier pages show a worsening picture for youth mental health prior to the COVID-19 pandemic. Graphics below show how that mental health picture has continued to worsen during the pandemic. School professionals presenting to the CFTF emphasized that the need for more mental health supports in schools has for years been critical, and that the impacts of the pandemic, which are expected to be present long after the pandemic itself subsides, are creating an even greater and more urgent need.

Specialized Instructional Support Ratios:

School Counselors

1 : 353

(Recommended 1:250)

School Nurses

1 : 1,007

(Recommended 1:750 or 1 per school)

School Social Workers

1 : 1,289

(Recommended 1:250)

School Psychologists

1 : 1,798

(Recommended 1:550)



LOOKING AT YOUTH MENTAL HEALTH:

Mental Health America collects information from people searching for online mental health resources and supports through its MHAScreening.org online tools. Data collected from screenings from January – September 2020 and published in the MHA report “COVID-19 and Mental Health: A Growing Crisis” showed the following:

- 38% of those accessing screening in 2020 were youth age 11 – 17, which is a nine percent increase over 2019.
- For 2020 screenings, youth ages 11 – 17 were more likely than any other age group to score for moderate to severe symptoms of anxiety and depression.
- Of 11 to 17 year-olds who took a screen at MHAScreening.org between March and September 2020:
 - Over 80% who took an anxiety screen scored for moderate to severe anxiety.
 - Over 90% who took a depression screen scored for moderate to severe depression.

ADMINISTRATIVE ITEM: Administrative support to follow implementation of new provisions in the NC Board of Education School Mental Health Policy that relate to strengthened school/community connections to address student mental health; information on implementation to be studied by the Intentional Death Prevention Committee prior to the 2022 legislative session.

The Intentional Death Prevention Committee discussed the importance of optimizing schools' ability to connect with existing mental health resources in communities. Although in-school support professionals are essential, strong community resources including school-community partnerships are necessary to be able to effectively address the mental health needs of students. During the same timeframe that the Intentional Death Prevention Committee was meeting in the fall of 2020, the North Carolina Board of Education adopted a new School Mental Health Policy that contains provisions related to strengthened school/community connections to address student mental health including:

- Public School Units (PSUs) shall offer to enter into Memorandums of Understanding with the LME/MCOs and/

or local mental health and substance use providers;

- inclusion in PSU mental health plans of strategies to improve access to community-based services; and
- efforts by PSUs to engage relevant stakeholders to support coordinated mental and social-emotional health and substance use supports and services for students.

The Intentional Death Prevention Committee recognized that these provisions in the new School Mental Health Policy demonstrate excellent steps toward strengthening school/community connections for addressing student mental health and the committee is interested in learning about implementation of these policies when it meets again in 2021.

ADMINISTRATIVE ITEM: Administrative support to explore and pursue possibilities for funding for a three-year lead suicide prevention coordinator position in North Carolina that would coordinate cross-agency efforts to carry out implementation of the 2015 NC Suicide Prevention Strategic Plan and determine a sustainability plan for ongoing statewide coordination for implementation of the Strategic Plan.

North Carolina has a statewide comprehensive suicide prevention plan created in 2015. This plan is the result of a collaborative 16-month process utilizing the input of approximately 180 diverse suicide prevention stakeholders. Unlike some other statewide prevention or action plans in North Carolina that rely on the collaborative efforts of many, the [2015 NC Suicide Prevention Plan](#)¹⁵ does not have a designated leader to coordinate implementation of strategies contained in the plan.¹⁶ With suicide rates increasing for all age groups, and especially with fears about the current pandemic's

impact on mental health, leadership in suicide prevention is essential.

Currently, suicide prevention efforts in North Carolina are facilitated and managed by government agencies, nonprofits, and academic institutions. Experts informing this recommendation agreed that while a great deal of excellent work is taking place across the state, having one individual and/or organization serving in a lead role would:

- provide a single source of support and coordinate information sharing in order to guide efforts and ensure best practice;

¹⁵ The 2015 N.C. Suicide Prevention Plan is available at www.injuryfreenc.ncdhhs.gov/preventionResources/docs/2015-NC-SuicidePreventionPlan-2015-0505-FINAL.pdf.

¹⁶ Examples of statewide plans with designated leaders include the Opioid Action Plan, the Early Childhood Action Plan, and the Perinatal Health Strategic Plan.

- serve as a catalyst to turn ideas and plans into action;
- help ensure various aspects of the 2015 statewide suicide prevention plan are being carried out and reduce duplication;
- help ensure efficient use and sharing of limited resources.

Experts who informed this recommendation articulated goals for this position that include: coordination of current interventions and research related to suicide prevention; coordination of funding for suicide prevention efforts; coordination of consistent messaging; coordination of priority strategies; monitoring of

outcomes; and consistency with training. They also highlighted the potential for this position to reside outside of a government agency.

In 2020, the Intentional Death Prevention Committee heard a presentation explaining new grant-funded suicide prevention work in North Carolina through the Division of Public Health. This work will include a state suicide prevention initiative that is similar to the way opioid prevention work and data have been approached in North Carolina. The initiative will bring together many stakeholders around common goals and this initiative would benefit from having a lead suicide prevention coordinator in place.

Recommendations to prevent infant deaths

Two-thirds of all child deaths in North Carolina are infants, less than one year of age. **In 2019, 810 infants died before their first birthday.**

The leading causes of infant death include prematurity/low birthweight, birth defects, maternal complications of pregnancy, and other perinatal complications. As explained below, deaths associated with unsafe sleep circumstances are another large category of infant deaths, and the first recommendation here is to expand efforts to prevent these deaths. The second recommendation below is to strengthen laws addressing the safe surrender of infants, and the third recommendation is meant to prevent perinatal tobacco use which is directly associated with leading causes of infant mortality.

Although the three legislative recommendations below directly address infant deaths, many of the other recommendations in this 2021 Action Agenda would also reduce infant deaths:

- Strengthening and restructuring the statewide Child Fatality Prevention System (see p. 13) would not only strengthen reviews of infant deaths in

order to better understand them, it would also strengthen the ability of the state and local communities to implement infant mortality prevention strategies.

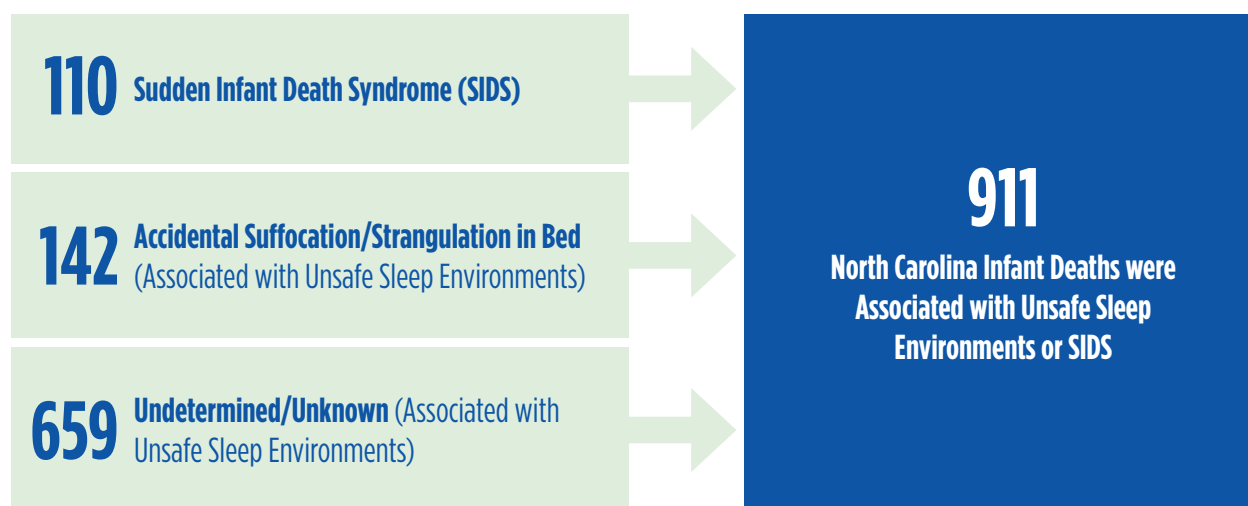
- Passage of pregnancy and lactation accommodations legislation as well as a kin care and safe days bill would strengthen the health and safety of infants and their families; see p. 36 for more about these recommendations, including the evidence supporting their impact on infants and families.
- Strengthening education and awareness around child abuse and neglect reporting would result in more adults recognizing and responding to signs of abuse and neglect to prevent harm or even death to an infant. Data show that the risk of abuse and neglect is greatest in the earliest months and years of life. See p. 43 for information on these recommendations.
- Recommendations to prevent motor vehicle-related deaths and injuries to children are aimed at children and youth of all ages, including infants. See p. 47.

LEGISLATIVE RECOMMENDATION: Support a state appropriation of \$85,000 in additional funding to expand the Safe Sleep NC program that works to prevent sleep-related infant deaths.

Sleep-related infant death remains a leading cause of infant mortality, both in North Carolina and nationally. According to the North Carolina Office of the Chief Medical Examiner, in the seven-year period 2012-2018, 911 infant deaths in North Carolina were associated with SIDS or unsafe sleep environments (for example, an infant found with his or her face covered by a blanket, found sleeping on a couch with the infant's face to the back of the couch or between cushions, sharing a sleep space with another individual).¹⁷

Many of these infant deaths are associated with bed sharing, also referred to as co-sleeping — the intentional or unintentional practice of an infant sharing a sleep space with another individual.¹⁸ More than 60% of mothers report bed sharing with their baby.¹⁹ In North Carolina, about half of new mothers surveyed indicated that their infant does not always sleep alone in their own crib or bed.²⁰ The common practice of bed sharing is concerning because of the dangers associated with it, especially among higher risk infants, including those born too soon, too small, or in households where tobacco and other substances are used.²¹

SUID CASES OCCURRING DURING SLEEP OR IN THE INFANT'S SLEEP AREA, NC 2012-2018



Source: Office of the Chief Medical Examiner-Division of Public Health North Carolina Department of Health and Human Services

WHAT'S AN UNSAFE SLEEP ENVIRONMENT?

Several elements contribute to an unsafe sleep environment for an infant, including:

- Sleeping in something other than a safety approved crib (e.g. sofa, adult bed)
- Bed-sharing (an infant sleeping with another person)
- Soft bedding (blankets, pillows)
- Bumper pads or other items in the crib
- Sleeping on their side or stomach

Education and support have been shown to reduce these risk factors and prevent deaths

¹⁷ Office of the Chief Medical Examiner, Division of Public Health, North Carolina Department of Health and Human Services.

¹⁸ Office of the Chief Medical Examiner, Division of Public Health, North Carolina Department of Health and Human Services.

¹⁹ Centers for Disease Control and Prevention, Vital Signs, Safe Sleep for Babies: www.cdc.gov/vitalsigns/safesleep/.

²⁰ North Carolina Pregnancy Risk Assessment Monitoring System Survey Results 2018, Sleep Position and Bed Sharing; Question: "In the past two weeks how often has your baby slept alone in his or her own crib or bed?"

²¹ American Academy of Pediatrics, 2016. SIDS and other sleep-related infant deaths: Updated 2016 recommendations for a safe infant sleeping environment, 138 (5) (2016), pp. 1-12, 10.1542/peds.2016-2938.

Research has found that parents need support navigating the challenges of nighttime parenting and that they would listen to health care providers if counseled about the dangers of the practice of bed sharing and given additional support in adhering to the safe infant sleep recommendations.²² Additionally, a study found that nearly half of caregivers did not receive correct advice on safe sleep practices from health care providers.²³ Provider advice is an important, modifiable factor to improve safe sleep practice. Expanded efforts to reach population groups with multiple overlapping risks — such as smoking, soft bedding, and bed sharing— are needed.²⁴ North Carolina health care providers have asked for support engaging parents and caregivers in nuanced conversations about sleep and nighttime parenting to help reduce the risk of infant death.²⁵

State funding for infant safe sleep programming to educate about the importance of safe sleep and prevent these types of deaths currently totals \$45,000. Not only is this level of funding insufficient to address so many preventable infant deaths, but the source of this funding matters. This \$45,000 in funding is currently designated in the state budget to come from the federal Maternal and Child Health Block Grant. When block grant funds are used for this type of purpose, as opposed to using general state funds for this purpose, whatever is designated in the block grant for this purpose is potentially being diverted away from other important maternal and child health initiatives.

Additional funding of \$85,000 for the Safe Sleep NC campaign would support the development and dissemination of training modules and resources for health care providers across the state. It would

also allow increased dissemination of education and information for new parents and other caregivers, including social media and marketing efforts, and would provide for outreach and training efforts for those involved with home visiting, early intervention, and other relevant areas. With this additional funding, North Carolina would be spending approximately \$1 per each infant in our state for safe sleep outreach.

Increased safe sleep concerns during pandemic

Experts who presented to the Task Force on the topic of infant safe sleep expressed increased concerns about safe sleep during the pandemic. The circumstances surrounding the pandemic make it more challenging for parents to learn about safe sleep recommendations from healthcare providers. Parents are also experiencing changes in their childcare and family routines, which can disrupt efforts to ensure safe sleep practices. The many impacts of the pandemic that result in increased stress and various disruptions may also result in increased susceptibility to substance use and misuse, addiction, and return to use and substance use can impact a parent or caregiver's ability to ensure a safe sleep environment.



²² Salm Ward and Balfour, 2016. Infant safe sleep interventions, 1990–2015: A review. *Journal of Community Health*, 41 (1) (2016), pp. 180-196, [10.1007/s10900-015-0060-y](https://doi.org/10.1007/s10900-015-0060-y); Moon et al., 2016. Safe infant sleep interventions: What is the evidence for successful behavior change? *Current Pediatric Reviews*, 12 (1) (2016), pp. 67-75, [10.2174/573396311666151026110148](https://doi.org/10.2174/573396311666151026110148).

²³ Colson ER, Geller NL, Heeren T, et al. Factors Associated With Choice of Infant Sleep Position. *Pediatrics*. 2017;140(3):e20170596.

²⁴ Hirai AH, Kortsmit K, Kaplan L, et al. Prevalence and Factors Associated With Safe Infant Sleep Practices. *Pediatrics*. 2019;144(5):e20191286.

²⁵ UNC Center for Maternal and Infant Health.

LEGISLATIVE RECOMMENDATION: Support legislative changes to strengthen North Carolina's Infant Safe Surrender law to make it more likely the law will be used in circumstances for which it was intended to protect a newborn infant at risk of abandonment or harm by making legislative changes to accomplish the following: 1) remove "any adult" from those designated to accept a surrendered infant; 2) provide information to a surrendering parent; 3) strengthen protection of a surrendering parent's identity; 4) incorporate steps to help ensure the law is only applied when criteria are met.

In 2001 North Carolina passed HB 275 (S.L. 2001-291) known by many as the "Infant Safe Surrender" law. This law was recommended and advanced by the NC Child Fatality Task Force. Such laws exist in every state, often called "safe haven" laws, and although they vary they are all designed to provide a safe alternative for a desperate parent of a newborn who may be tempted to engage in actions harmful to the infant. The 2001 Safe Surrender law altered some provisions in the NC Juvenile Code as well as some criminal law provisions to decriminalize abandonment of a newborn infant under certain circumstances and to modify some procedures involving abandoned newborns. In recent years the Child Fatality Task Force, with input from experts in juvenile law, examined the Safe Surrender law and developed these recommended changes to strengthen the law.²⁶

The first change is to remove "any adult" from those designated to accept a surrendered infant. Currently, the law requires four categories of professionals to accept a safely surrendered infant and says also that "any adult" "may" accept a safely surrendered infant. There are several reasons why the recommendation was made to change this aspect of the law: "any adult" cannot be trained about the requirements of the law nor can "any adult" be expected to provide accurate information about the law to a surrendering parent; there are concerns about human trafficking and unlawful custody transfer when "any adult" may claim an infant was surrendered to him or her pursuant to the law; this kind of "any adult" category is not typical in other states.

The second change involves providing information to a surrendering parent.

Currently, no information about safe surrender is required to be provided to a parent who surrenders an infant in North Carolina. If and when information may be provided, there is no means for ensuring accuracy, consistency, or quality of that information. When possible, surrendering parents should be given accurate information regarding consequences, rights, and options related to safe surrender. Especially since many surrenders are occurring in hospitals after delivery, ensuring that a surrendering parent has good information and resources may yield a different choice by the parent that is ultimately better for both parent and child. This can be accomplished by adding a provision to the law that when possible, a surrendering parent be given information regarding safe surrender requirements, consequences, seeking reunification, voluntarily relinquishment of parental rights, a form to collect medical history information, and available services for help with relevant contact information. To ensure consistency and accuracy, the law can also require that DHHS develop written material that addresses the above information to be used across the state by those eligible to accept a surrendered infant (information can be easily downloaded from the web and local contact information can be filled in).

The third change involves strengthening protection of a surrendering parent's identity. Even though a surrendering parent in North Carolina does not have to give his or her identity at the moment of surrender,

²⁶ For more information on CFTF work on Infant Safe Surrender that led to these recommendations, see the 2018 CFTF Annual Report.

current NC law requires the Division of Social Services (DSS) to treat the case the same as any other abuse, neglect, or dependency case once they receive custody – this includes making immediate diligent efforts to identify and locate the surrendering parent for participation in all juvenile proceedings regarding the infant. Protections of a surrendering parent’s identity are a critical aspect of safe surrender/safe haven laws in general, as a parent who believes that his or her identity has protections related to safe surrender may be more likely to use the law in circumstances for which it was intended – to protect a newborn infant at risk of abandonment or harm. Many other states have stronger protections for the identity of a surrendering parent compared to North Carolina. Areas of the North Carolina law where statutory changes could be considered to accomplish strengthening these protections (without changing a non-surrendering parent’s rights) include: confidentiality provisions addressing information shared about identity; modification of the immediate response by

DSS in safe surrender cases; modification of juvenile court process related to the surrendering parent.

The last change would incorporate steps to help ensure the law is only applied when criteria are met. More effort should be taken to ensure safe surrender protections are only available when criteria set out in the law are met because the law provides protections for a surrendering parent with respect to immunity and identity. The types of statutory changes that could be considered to accomplish this include: adding a definition of “safely surrendered infant” and “surrendering parent” for clarification; requiring that the infant be reasonably believed to be under seven days old and without signs of abuse or neglect at the time of surrender; requiring that DSS ascertain from a health care provider that the surrendered infant is, to a reasonable medical certainty, under seven days old and without signs of abuse or neglect; adding a provision that emphasizes that safe surrender law provisions are only applicable when criteria are met.

LEGISLATIVE RECOMMENDATION: Endorse additional QuitlineNC funding of \$3 million

Helping people quit tobacco is important for the health of infants and youth. More than one in 12 babies in North Carolina are born to mothers who report smoking during pregnancy; in some counties, over 25% of babies are born to women who smoke.²⁸ Maternal smoking is also causally associated with ectopic pregnancy and orofacial clefts.²⁹ As more youth become addicted to nicotine through use of electronic cigarettes the need to provide services to help them quit increases (“ENDS” = electronic nicotine devices – see recommendation beginning on p. 50).

QuitlineNC provides free assistance to help people quit tobacco through an evidence-

Tobacco use during pregnancy is directly associated with the top causes of infant mortality in North Carolina.²⁷

based telephone tobacco treatment program; an interactive web-based tobacco treatment program (which can be combined with telephone coaching or stand-alone) and texting; coaching calls with highly trained multilingual coaches; and starter kits of nicotine patches for Medicaid and Medicare recipients and eight weeks of combination therapy (patches plus gum/lozenges) for

²⁷ University of North Carolina Center for Maternal and Infant Health, You Quit Two Quit, 2018.

²⁸ North Carolina Selected Vital Statistics Vol. 1 2018, NC State Center for Health Statistics <https://schs.dph.ncdhhs.gov/data/vital/volume1/2018/nc.html>.

²⁹ U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

uninsured residents. Studies show that coaching, when combined with FDA-approved tobacco treatment medications, such as nicotine replacement therapy, triples a tobacco user's chances of quitting successfully compared with quitting without assistance.³⁰ QuitlineNC also has a special protocol for pregnant individuals who call the line to provide additional support.

Not only is quitting important for health reasons, but it also has an economically positive impact. For every dollar spent in

FY2011, QuitlineNC provided \$2.55 return on investment; however, this was based on coaching services alone, without tobacco treatment medication.³¹ This return on investment increases with adequate funds to treat all tobacco users with at least four coaching calls and 8-12 weeks of nicotine patches and gum. Providing nicotine replacement therapy and QuitlineNC services increased the State Health Plan's (SHP) return on investment. For every dollar spent, SHP was provided \$3.95 return on investment.

TOBACCO USE CAUSES POOR BIRTH & INFANT OUTCOMES

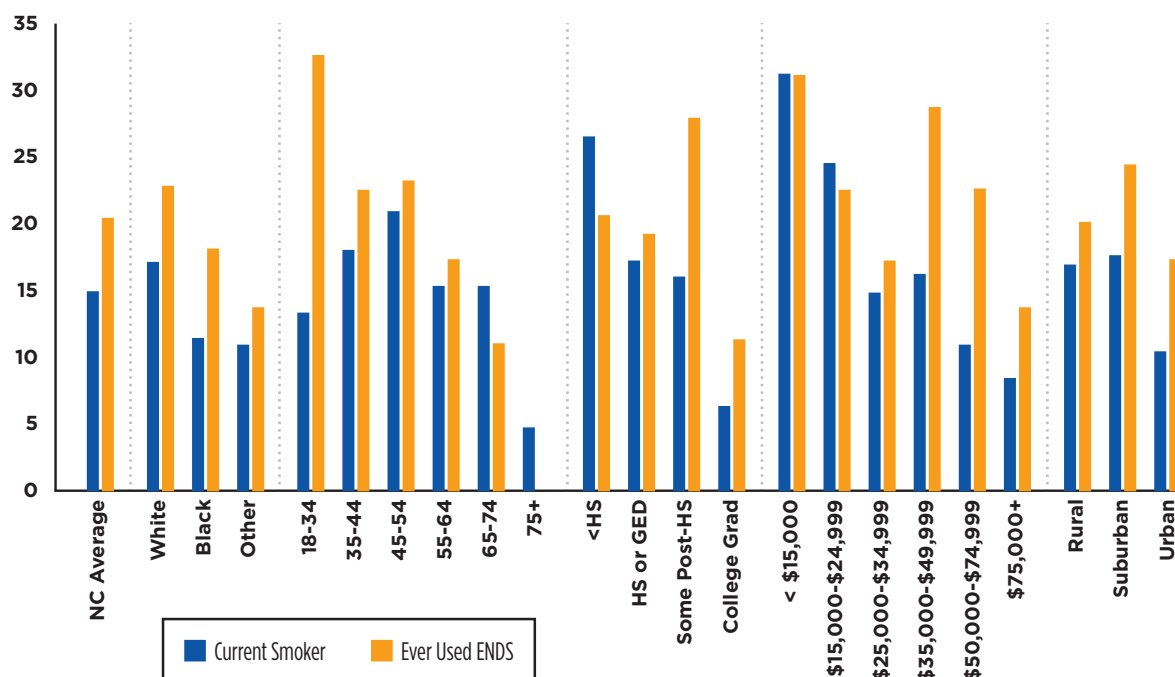
Maternal/Fetal Harm From Tobacco

- Infertility
- Miscarriage
- Ectopic Pregnancy
- Premature Birth
- Low Birth Weight
- Stillbirth
- SIDS

Infant/Child Harm From Tobacco

- SIDS
- Ear infections
- Respiratory Infections
- Asthma
- Links with childhood obesity, cancer, & attention disorders, and cardiovascular disease & diabetes in adulthood

WOMEN & TOBACCO USE IN NC, 2018



Source: NC State Center for Health Statistics. Available from: <https://schs.dph.ncdhhs.gov/data/brfss/2017/nc/female/topics.htm>

³⁰ Zbikowski SM, et.al. "North Carolina Tobacco Use Quitline Final Comprehensive Evaluation Reports." Free & Clear, Inc. & Alere Wellbeing Inc. 2006-2016; Fiore MC, Bailey WC, Cohen SJ, et. al. Treating Tobacco Use and Dependence: A Clinical Practice Guideline. US Department of Health and Human Services. Public Health Service, 2008.

³¹ Tobacco Prevention and Control Branch and Health and Wellness Trust Fund QuitlineNC Financial Reports. FY11.

Recommendations on workplace supports to strengthen child and family health, well-being, and economic stability

North Carolina's infant mortality rate has improved but nevertheless remains among the worst dozen in the nation, and two-thirds of all child deaths in North Carolina are to infants under one year. Maternal and child health experts who have presented to the Child Fatality Task Force have emphasized that in order to see the infant mortality rate and the child death rate decline in North Carolina, strategies that focus on social determinants of health are critical, and a priority among these determinants is economic stability. Economic stability is impacted by employment, and an individual's well-being (and therefore a family's well-being) may also be impacted by workplace circumstances.

Strategies that focus on workplace supports for families are aligned with goals in two statewide plans that address infant and child well-being, as well as recent recommendations made by a North Carolina Institute of Medicine (IOM) Task Force. Representatives of these two plans and the IOM have presented to the Child Fatality Task Force and/or the Perinatal Health Committee of the Child Fatality Task Force. A main goal of the **North Carolina Perinatal Health Strategic Plan**, which is designed to reduce infant mortality in North Carolina, is to address social and economic inequities. Within that goal is the strategy to "support working mothers and families" which includes the goal to "create and expand paid parental and sick leave policies" and "create and expand safe work place environments

Strategies focused on workplace supports for families are aligned with goals in the NC Perinatal Health Strategic Plan, the NC Early Childhood Action Plan, and recommendations in the NC Institute of Medicine's Task Force on Building a Perinatal System of Care.

and accommodations for pregnant and breastfeeding women."³² The **North Carolina Early Childhood Action Plan** also has multiple goals that center on improving families' economic stability in order to improve outcomes for young children in North Carolina. This plan specifically promotes "encouraging breastfeeding-friendly policies and services in local communities" and "promoting family-friendly work places, such as paid sick leave, paid parental leave and reliable work schedules."³³ In addition, recommendations from the **North Carolina Institute of Medicine's Task Force on Building a Perinatal System of Care** includes a recommendation that "North Carolina employers, including the state, should provide pregnancy accommodations such as paid family and medical leave, paid sick days, and pregnancy and breastfeeding accommodations."³⁴

³²The North Carolina Perinatal Health Strategic Plan is available on the NC Division of Public Health website here: <https://whb.ncpublichealth.com/phsp/>.

³³North Carolina Early Childhood Action Plan, February 2019, see page 42: <https://files.nc.gov/ncdhhs/ECAP-Report-FINAL-WEB-f.pdf>.

³⁴North Carolina Institute of Medicine. (April, 2020). *Healthy Moms, Healthy Babies: Building a Risk-Appropriate Perinatal System of Care for North Carolina*, see page 47. Available at: <http://nciom.org/wp-content/uploads/2020/04/Perinatal-Report-FINAL.pdf>. (Recommendations from this IOM Task Force were presented to the Child Fatality Task Force Perinatal Health Committee prior to publication of the report.)

Employers, employees, and the overall economy are currently impacted by workers struggling to balance work and family.

- 65% of North Carolina children live in households where all available parents are currently working.³⁵
- Two-thirds of mothers with children under age six are in the U.S. labor force, and three-quarters of mothers with children under 18 are in the labor force.³⁶
- In North Carolina, about 44% of mothers are the sole or primary breadwinner for their families, earning at least half of their total household income, and an additional 21% of mothers are married mothers whose wages comprise at least 25% of total household earnings.³⁷
- A North Carolina survey showed that 75% of mothers and 50% of fathers say they have passed up work opportunities, switched jobs, or quit to care for their children, and nearly 40% of parents say they've left a job because it lacked flexibility.³⁸
- Workers are frequently caregivers to family besides their own children. More than 1 in 6 American workers assists with the care of an elderly or disabled family member, relative, or friend.³⁹



Workplace policies that support the realities of balancing work and family help with labor force participation, productivity, morale, retention, and more. Many employers who have adopted family-friendly work policies and benefits have done so because they believe that such policies are good for their business.⁴⁰ A North Carolina survey of employers of all sizes showed that employers see family-friendly practices as an effective way to grow a more prosperous company.⁴¹

³⁵ NC Council for Women and Youth Involvement and Institute for Women's Policy Research. (June, 2018). *Status of Women in NC: Employment and Earnings*. North Carolina Department of Administration. <https://ncadmin.nc.gov/advocacy/women/status-women-north-carolina>.

³⁶ U.S. Bureau of Labor Statistics. (April, 2020). *Employment Characteristics of Families Summary, 2019*. www.bls.gov/news.release/famee.nr0.htm.

³⁷ Glynn, S.J. Center for American Progress. (May 10, 2019). *Breadwinning Mothers Continue to Be the U.S. Norm*. www.americanprogress.org/issues/women/reports/2019/05/10/469739/breadwinning-mothers-continue-u-s-norm/.

³⁸ Family Forward NC, North Carolina Early Childhood Foundation. (2018). *North Carolina Employers Agree: Family-friendly practices are good for business*. https://files.familyforwardnc.com/wp-content/uploads/2018/04/Family-Forward-Research-Report_Online_091218.pdf.

³⁹ Family Caregiver Alliance. *Caregiver Statistics: Work and Caregiving*. www.caregiver.org/caregiver-statistics-work-and-caregiving.

⁴⁰ See Family Forward NC, North Carolina Early Childhood Foundation. (2018). *North Carolina Employers Agree: Family-friendly practices are good for business*. https://files.familyforwardnc.com/wp-content/uploads/2018/04/Family-Forward-Research-Report_Online_091218.pdf.

⁴¹ Family Forward NC, North Carolina Early Childhood Foundation. (2018). *North Carolina Employers Agree: Family-friendly practices are good for business*. https://files.familyforwardnc.com/wp-content/uploads/2018/04/Family-Forward-Research-Report_Online_091218.pdf.

Policies that support working women are even more critical during the pandemic.

Consider that women, disproportionately women of color, are on the front lines of the COVID-19 crisis. According to the Center for Economic and Policy Research, nearly two-thirds of frontline workers are women, and people of color are overrepresented in these industries. Here is an example of the data that was presented to the Task Force:

Industry	Female (%)	People of Color (%)
Building cleaning: housekeeping	90.7	69.8
Childcare workers	95.0	44.8
Home health care services	87.5	53.0
Nursing care facilities	84.2	44.6
Cashiers	71.8	44.6



The following two recommendations by the Task Force are “endorse” items on the Child Fatality Task Force agenda which means that these recommendations are being advanced by other organizations and the Task Force is endorsing the advancement of these policies.⁴²

LEGISLATIVE RECOMMENDATION: Endorse passage of a kin care and safe days bill that would guarantee all North Carolina workers the right to use their sick days (whether paid or job-protected unpaid) to care for a sick loved one, seek preventative care, or deal with the physical, mental, or legal impacts of domestic violence, sexual assault, or stalking.

About three-quarters of workers have access to some type of paid sick leave,⁴³ and others may have unpaid but job-protected sick leave, but the form that sick leave takes varies considerably. This recommendation is for legislation that would give North Carolina workers the right to use existing sick leave (whether paid or job-protected unpaid) to care for a sick loved one, seek preventative care, or deal with the physical, mental, or legal impacts of domestic violence, sexual assault, or stalking; it does not address the overall amount of sick leave provided by employers or whether that leave time is paid or unpaid.

Many workers are not only responsible for their own health, but they care for the health of other family members. Of course, parents are caring for children, but many workers are also providing care to other family members. Being healthy is not just about reacting to illness or

injury, it's also about preventing illness or injury. Prevention could mean taking time to go to the doctor for wellness checks or vaccinations, but it may also mean taking the time to protect oneself and one's family from intimate partner violence or to deal with its impacts. The ability to take time off from work for preventive care, not just for illness, is especially important for pregnant women who need to have consistent prenatal visits.

Safe Days Leave

Intimate partner violence has devastating impacts for children. More than one in three North Carolina women have experienced at least one type of intimate partner or sexual violence in their lifetime.⁴⁴ The Centers for Disease Control and Prevention reports that about one in four women and nearly one in 10 men have experienced contact sexual violence,

⁴² The Task Force has not at this time studied or made recommendations regarding the composition or inclusion of specific provisions or language in potential laws addressing these recommendations.

⁴³ 2019 National Compensation Survey, U.S. Bureau of Labor Statistics.

⁴⁴ Shaw, E. & Tesfaselassie, A. (2019). *The Status of Women in North Carolina: Health & Wellness*. Institute for Women's Policy Research, commissioned by the North Carolina Council for Women and Youth Involvement. North Carolina Department of Administration. https://files.nc.gov/ncdoa/cfw/documents/R592_NC_Health_Report_Final.pdf.

physical violence, and/or stalking by an intimate partner during their lifetime and reported some form of intimate partner-related impact.⁴⁵

Research suggests that in 30% to 60% of families where domestic violence is identified, child maltreatment is also occurring.⁴⁶ Children's exposure to domestic violence can have immediate and long-term impacts, including social and emotional problems, attitudinal problems, higher risk of delinquency and substance use, higher risk for entering into abusive relationships or becoming abusers, and other health impacts.⁴⁷ "Safe days leave" allows leave time to be used for steps to prevent violence or deal with the impacts of intimate partner violence.

In October 2019, Governor Cooper signed an Executive Directive enabling eligible employees of departments and agencies that are under the governor's oversight to use their earned sick and vacation leave to address intimate partner violence, to seek counsel from an attorney or social services provider, participate in legal proceedings such as filing a restraining order, relocate to a safe location, or take other steps necessary to secure and restore their health and safety. Legislation is needed for safe days leave to be available beyond these state employees covered by the governor's Executive Directive.

Kin Care Leave, Preventive Care & the Importance of Preventing the Spread of Contagious Disease

The COVID-19 pandemic brought into focus the importance of people being able to stay home when they are sick, not only to get better but to prevent infecting others if they are contagious. Parents need to be able to use their sick leave to stay home with a sick child or to get children to wellness visits so that they aren't forced to choose between economic stability and the health of their loved ones or others that may be infected if they or their children go to work or school sick.

Besides caring for their own children, many workers are called upon to care for or help other family members.

With kin care leave of the type being discussed here, sick leave can be used to care for a child who has a temporary illness, such as a contagious illness like the flu, or to care for an elderly parent immediately following surgery. Kin care laws vary; a proposed kin care and safe days leave bill in North Carolina in 2019 limited this type of leave used to care for family members to five days.⁴⁸

It should be noted that the Child Fatality Task Force did not take up the issue of paid short-term sick leave, as this kin care

Taking time for preventive care is critical. According to the 2019 NC Child Health Report Card:

- *Only 57.7% of NC children with Medicaid received a well-child checkup in the past year*
- *Only 73.6% of Children ages 19-35 months had received appropriate immunizations*

⁴⁵ Centers for Disease Control and Prevention. *Violence Prevention, Fast Facts, Intimate Partner Violence*. www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html.

⁴⁶ Domestic Violence and Child Abuse, Children's Hospital of Philadelphia Center for Violence Prevention. <https://violence.chop.edu/types-violence/domestic-violence-and-child-abuse>.

⁴⁷ See Effects of Domestic Violence on Children. Office on Women's Health, U.S. Department of Health and Human Services. www.womenshealth.gov/relationships-and-safety/domestic-violence/effects-domestic-violence-children.

⁴⁸ The proposed legislation in North Carolina in 2019 was House Bill 899, which had bipartisan sponsorship. Note: The Child Fatality Task Force was not involved in this specific 2019 bill.

recommendation addresses using both paid and unpaid sick leave for the purpose of caring for a family member.

Data related to the flu provides relevant information on the importance of all family members needing leave time for preventative care, including flu shots and staying home when sick. There have been studies examining the impact of leave time on the spread of influenza, although these types of studies typically look at paid leave. Studies indicate that children of parents with paid time off are 13% more likely to have well-child visits and flu vaccines, and parents without paid sick days are twice as likely to

send a sick child to school or child care.⁴⁹ A lack of paid sick leave has been associated with a lower likelihood of workers getting flu vaccinations.⁵⁰ One study comparing flu rates in cities with and without mandatory paid leave showed an infection rate could be 40% lower in a city with paid leave.⁵¹ Another study showed how providing paid sick leave could have saved employers from \$630 million to \$1.88 billion in reduced absenteeism costs per year related to flu-like illness from 2007-2014.⁵² In this way, there are both public health and economic benefits from ensuring leave time to reduce the spread of disease.

LEGISLATIVE RECOMMENDATION: **Endorse legislation that would guarantee all North Carolina workers the right to reasonable pregnancy and lactation accommodations in the workplace.**

Each year, about 1.6% of the North Carolina labor force gives birth.⁵³ Healthy birth outcomes depend on a healthy pregnancy, and the health benefits of breastfeeding to both mothers and infants are well documented. A woman's ability to care for her health during pregnancy and to succeed at breastfeeding can be impacted by the physical and logistical demands of her job and whether she receives reasonable accommodations from her employer to address these demands.

Jobs that may involve increased exposure to toxins, disease, or physical hazards pose some of the more obvious risks for pregnant women. In addition, physically demanding

work may increase risk for pre-term birth.⁵⁴ In North Carolina, prematurity and low birth weight are leading causes of infant mortality, and another leading cause involves "maternal complications" which can relate to the mother's health.⁵⁵ Many women have jobs and/or uncomplicated pregnancies that require no workplace accommodations or only minor ones to stay healthy, but when accommodations are needed it's important that laws and policies facilitate, rather than impede, a woman's ability to get them. The American College of Obstetricians and Gynecologists issued an opinion highlighting the importance of pregnancy accommodations in the workplace for women who need them.⁵⁶

⁴⁹ Presentation by NC Pediatric Society to the Perinatal Health Committee of the NC Child Fatality Task Force, October 28, 2019.

⁵⁰ Zhai Y, Santibanez TA, Kahn KE, Black CL, de Perio MA. Paid sick leave benefits, influenza vaccination, and taking sick days due to influenza-like illness among U.S. workers. *Vaccine*. 2018;36(48):7316–7323. doi:10.1016/j.vaccine.2018.10.039.

⁵¹ VOX CEPR Policy Portal. Pchler, S. & Ziebarth, N.R. (May 12, 2018). *The pros and cons of sick pay schemes: Contagious presenteeism and noncontagious absenteeism behavior*. <https://voxeu.org/article/pros-and-cons-sick-pay>.

⁵² Asfaw, A., Rosa, R., & Pana-Cryan, R. (2017). Potential economic benefits of paid sick leave in reducing absenteeism related to the spread of influenza-like illness. *Journal of occupational and environmental medicine*, 59(9), 822-829.

⁵³ National Women's Law Center. (March, 2013). *Pregnant Workers Make Up a Small Share of the Workforce and Can Be Readily Accommodated: A State-By-State Analysis*. www.nwlc.org/sites/default/files/pdfs/state_by_state_analysis.pdf.

⁵⁴ See: van Beukering, M.D.M., van Melick, M.J.G.J., Mol, B.W. et al. Physically demanding work and preterm delivery: a systematic review and meta-analysis. *Int Arch Occup Environ Health* 87, 809–834 (2014). <https://doi.org/10.1007/s00420-013-0924-3>.

⁵⁵ Child Deaths in North Carolina, Annual Report for 2018, produced by the N.C. Division of Public Health – Women's and Children's Health Section in conjunction with the State Center for Health Statistics.

⁵⁶ American College of Obstetricians and Gynecologists. (April, 2018). *Employment Considerations During Pregnancy and the Postpartum Period*. Committee Opinion number 733.

Over one in five pregnant workers are employed in low-wage jobs, which are particularly likely to be physically demanding, and women of color are disproportionately represented in these low-wage jobs.⁵⁷ Some of the most common occupations for pregnant workers include: school teachers, nurses, cashiers, administrative assistants, health aids, customer service representatives, food servers, and retail sales.⁵⁸

Examples of workplace adjustments that can promote a healthy pregnancy include:

- assistance with manual labor, such as help with heavy lifting;
- changes in uniform or protective gear;
- access to food and drink and permitting meals and beverages at work stations;
- more frequent and longer breaks;
- changes in a work station or seating equipment (e.g., for a position that typically involves standing, provide a stool);
- modified work assignments (with respect to schedule or physical demands).

Three months after giving birth, more than half of U.S. women who worked during pregnancy have returned to work,⁵⁹ and a study based on U.S. Census data estimated that nearly one in four women are back at work within two weeks of giving birth.⁶⁰ Experts recommend breastfeeding for one year with exclusive breastfeeding for at least six months following birth.⁶¹ While over 80% of infants born in the U.S. start out breastfeeding, less than half are exclusively



breastfed at three months and only one-third are breastfeeding at six months.⁶² A worksite environment that impedes a woman's ability to express breast milk is one of the barriers women face in continuing to breastfeed for a year after giving birth.

More than half of all states have enacted laws to address accommodations for pregnancy because federal laws are seen as falling short of necessary protections

There are federal laws that address some workplace accommodations related to pregnancy, such as the Pregnancy Discrimination Act (PDA), Americans with Disabilities Act (ADA), and Affordable Care Act (ACA). However, there is no federal law guaranteeing comprehensive accommodations for pregnant and postpartum workers. While most employers honor requests for reasonable accommodations, one report estimated that 250,000 pregnant workers every year are denied requests for accommodations while more don't bother asking for fear of retaliation.⁶³ Federal laws as interpreted by the

⁵⁷ Harwood, M. & Heydemann, S. (August, 2019). *By the Numbers: Where Do Pregnant Women Work?* National Women's Law Center. <https://nwl.org/wp-content/uploads/2019/08/Pregnant-Workers-by-the-Numbers-v3-1.pdf>.

⁵⁸ Ibid.

⁵⁹ See Laughlin, L. United States Census Bureau. (October, 2011). *Maternity Leave and Employment Patterns of First-Time Mothers: 1961 - 2008*, Household Economic Studies. www.census.gov/prod/2011pubs/p70-128.pdf.

⁶⁰ In These Times. (August 18, 2015). *The Real War on Families: Why the U.S. Needs Paid Leave Now*. <http://inthesetimes.com/article/18151/the-real-war-on-families>.

⁶¹ Association of Maternal and Child Health Programs. (August, 2017). *Promoting Workplace Breastfeeding Accommodations: Regulations, Best Practices, and the Critical Role of Title V Programs*. www.amchp.org/Policy-Advocacy/health-reform/resources/Documents/Kellogg_WorkplaceBreastfeedingAccommodations.pdf.

⁶² Centers for Disease Control and Prevention. (2018). *Breastfeeding Report Card, United States, 2018*. www.cdc.gov/breastfeeding/data/reportcard.htm

⁶³ National Partnership for Women & Families. (January, 2014). *Listening to Mothers: The Experiences of Expecting and New Mothers in the Workplace*, Childbirth Connection, National Partnership for Women & Families. www.nationalpartnership.org/our-work/resources/economic-justice/pregnancy-discrimination/listening-to-mothers-experiences-of-expecting-and-new-mothers.pdf.

courts have been viewed as frequently falling short of providing necessary protections.⁶⁴ As a result, at least half of all states now have their own laws that provide protections and there have been recent bipartisan efforts to expand protections under federal law.⁶⁵

In December 2018, Governor Roy Cooper issued Executive Order 82, which addresses protections afforded to pregnant state employees who work for any North Carolina department or agency for which the governor has oversight responsibility. Without a state law, however, only a very limited number of North Carolina workers are covered by these protections. In 2019, a bipartisan bill was introduced in North Carolina to address pregnancy accommodations, but this bill did not become law (the Child Fatality Task Force was not involved in the 2019 bill).⁶⁶

Employer impact, economic issues, and bipartisan support

The percent of workers who need accommodations related to pregnancy and lactation is relatively small and most accommodations needed are minor. Each year 1.6% of the state's labor force gives birth and only a portion of these workers require more than minor accommodations — like

more frequent bathroom breaks. Whether the accommodation relates to pregnancy or breastfeeding, the circumstances requiring accommodation are temporary.

Laws and/or resulting policies addressing accommodations can increase employee retention and morale which saves turnover costs. With 72% of mothers with children under age 18 in the work force and 62% of mothers with children under age 3 in the workforce,⁶⁷ having policies that support and help keep women in the workforce results in economic benefits overall, as well as individual benefits that are frequently critical for a household to maintain economic security. Employers have often supported pregnancy accommodation laws because they create a clear standard for accommodating pregnant workers, and the response from Chamber of Commerce organizations to such laws is typically supportive or neutral.⁶⁸ State-level pregnancy accommodation laws passed since 2013 have frequently had bipartisan or in some cases unanimous support, and the pregnancy accommodations bill introduced in North Carolina in 2019 had bipartisan support as well.

⁶⁴ Under current law, the federal Pregnancy Discrimination Act (PDA) of 1978 mandates that pregnant workers be able to participate fully and equally in the workplace and prohibits discrimination based on pregnancy, childbirth, or related medical conditions. However, the report "Long Overdue" (referenced in the footnote below) states that many women who seek accommodations under doctor's orders and are refused by employers are unable to make valid claims under the PDA because of its limitations and the way it has been interpreted by courts. The federal Americans with Disabilities Act (ADA) requires employers to provide reasonable accommodations to workers with disabilities and although some pregnancy-related disabilities apply, pregnancy itself is not a disability, which leaves gaps in accommodations protections. The federal Affordable Care Act (ACA) amended Section 7 of the Fair Labor Standards Act to require employers to provide women with adequate break time to express breast milk for one year after child birth and for employers to provide a private, clean space to pump (other than a bathroom) as well as break times to do so; the break time requirement does not apply to employers with fewer than 50 employees if they can show an undue hardship.

⁶⁵ See Bakst, D., Gedmark, E., Brafman, S. (May, 2019). Long Overdue: It Is Time for the Federal Pregnant Workers Fairness Act. A Better Balance, The Work and Family Legal Center. www.abetterbalance.org/wp-content/uploads/2019/05/Long-Overdue.pdf. Also see the federal Pregnant Workers Fairness Act, H.R. 2694: www.congress.gov/bill/116th-congress/house-bill/2694.

⁶⁶ North Carolina Senate Bill 558, introduced April 2, 2019.

⁶⁷ U.S. Bureau of Labor Statistics for 2019.

⁶⁸ See Bakst, D., Gedmark, E., Brafman, S. (May, 2019). Long Overdue: It Is Time for the Federal Pregnant Workers Fairness Act. A Better Balance, The Work and Family Legal Center. www.abetterbalance.org/wp-content/uploads/2019/05/Long-Overdue.pdf.

Recommendations to strengthen education and awareness around child abuse and neglect reporting

In 2018, 2019, and 2020 the State Child Fatality Prevention Team recommended that the Child Fatality Task Force examine the issue of Child Abuse and Neglect Reporting (CAN reporting) and make efforts with increased education and awareness surrounding North Carolina's child abuse and neglect reporting law.

Abuse and Neglect Reporting

- The State Child Fatality Prevention Team (CFPT) reviewed the deaths of children who died in 2018 as a result of child abuse homicide by parent or caregiver. Local and State CFPT note similar trends among children's deaths related to abuse and/or neglect. There continues to be a disconnect between the state's mandatory reporter law, the training and education provided to professionals, and the public to execute their responsibilities as a NC citizen.
- Current and previous years' child death review trends include alleged abuse not being reported until death, lack of awareness from community members of their responsibility to report, and the expectations of the reporting process.



Experts presenting to the Intentional Death Prevention Committee during the past few years provided information on the law addressing CAN reporting, the current system of reporting, data on reports made, and the current situation related to CAN reporting education and awareness. The Intentional Death Prevention Committee examined and discussed the challenges of the current system; what can be learned from other research, evaluations, and recommendations related to CAN reporting; and what can be learned from other states. They discussed potential actions to address CAN reporting challenges in North Carolina, considering such actions in the current context of what may be feasible now compared to what may be feasible in the future.

Progress made on strengthening child abuse and neglect reporting education and awareness

During this past study cycle, the Intentional Death Prevention Committee heard presentations on the progress made to address the following three administrative items related to strengthening child abuse and neglect reporting education and awareness from the 2020 CFTF Action Agenda:

- Administrative support for the North Carolina Division of Social Services in the development of more robust and user-friendly web pages dedicated to education and information on child abuse and neglect reporting which includes information on prevention resources and services, what happens to the family and reporter once a report is made, and resources for learning more such as a link to video training. DSS should also ensure that NCCARE360 includes information

on CAN reporting, and web techniques should be used to make it more likely that relevant web searches will show NC DSS webpages focused on abuse and neglect reporting as a primary source of information in North Carolina.

- Administrative support for work being done by Prevent Child Abuse NC through its contract with NC Division of Social Services to develop training and collateral materials addressing child abuse and neglect reporting to support broad education of professionals and the public.
- Administrative support for contacting the Justice Academy about including training on child abuse and neglect reporting for training of law enforcement officers.

The North Carolina Division of Social Services (DSS) and Prevent Child Abuse North Carolina (PCANC) worked both independently and collaboratively with one another to make progress in the following areas and they reported this progress to the Intentional Death Prevention Committee:

- DSS greatly improved the quality and quantity of the content as well as the web navigation and searchability related to the topic of child abuse and neglect reporting on the NC DSS and DHHS websites.
- NCCARE360 now includes information on CAN reporting, including a training video on reporting.
- Even though NC does not have a statewide hotline for CAN reporting, NCDHHS has a webpage with various hotlines that includes the county contact list to call to report CAN.
- PCANC is working to update and strengthen its free online training “Recognizing and Responding to Child Maltreatment” (R&R training) and now has a Spanish version of the training.

- PCANC employs numerous online resources, some of which can be downloaded, and social media tools to disseminate information about CAN reporting and the R&R training.
- COVID-19 Resources: NCDHHS and PCANC collaborated on a “COVID-19 Parent & Caregiver Resource Guide” to help parents and caregivers navigate the challenges of the pandemic. They also created flyers targeting educators and essential workers to help educate these individuals on how they play a role during a shutdown of recognizing and reporting suspicions of abuse and neglect.

The Intentional Death Prevention Committee heard a presentation about current and potential avenues of training for law enforcement to receive increased education about child abuse and neglect reporting. However, the committee is not aware of any specific new state-level initiatives focused on CAN reporting training for law enforcement officers, so is interested in continuing work in this area.

Pandemic Impact: increased concerns about child abuse and neglect

Since the start of the pandemic when shutdowns were occurring across the country, experts in child welfare and safety, including members of the Task Force Executive Committee, expressed concerns about increased risks of child maltreatment. For some children prior to the pandemic, school may have been a safe place away from a home environment that may have involved circumstances of repeated stress or insecurity, or in worst cases maltreatment, but for much of 2020 many children were not in school. With families spending more time home together during the pandemic, changing many daily routines, and many facing enormous additional stressors related to income, home schooling, food or housing insecurity and

so many other challenges, some children have inevitably faced greater risks during the pandemic. Add to this the fact that there are fewer adult eyes on children, especially those that may be most likely to report suspected maltreatment, and the concerns increase about reports not being made.

North Carolina DSS provided data to the Intentional Death Prevention Committee on CAN reporting and reporters, some

of which was focused on identifying any differences during the pandemic. The types of professionals who most often make child abuse and neglect reports are, in order of professional categories who report the most: law enforcement or court personnel, medical personnel, educational personnel, and human services personnel.

Data in the graphics below illustrate the changed trends in reporting during 2020.

IMPACT OF COVID-19 ON REPORTS MARCH – JUNE 2020

Educational Personnel SFY 2019 – 2020

- Average 15.56% *
- February 2020: 26.85%
- March 2020: 18.48%
- April 2020: 3.7%
- May 2020: 3.39%
- June 2020: 1.3%

SFY 2015–2016 thru SFY 2018–2019

Consistently the average percentage of reports made by educational reporters

- 18%

IMPACT OF COVID-19 ON CHILD PROTECTION REPORTS

Comparison of Total Reports January through June 2019–2020

Year	January	February	March	April	May	June
2019	11,760	10,977	11,820	11,866	13,244	9,797
2020	12,169	11,366	10,531	7,889	8,749	9,414
% Difference	3%	4%	-11%	-34%	-34%	-4%



LEGISLATIVE RECOMMENDATION: Legislation that would add child abuse and neglect reporting requirements to the topic list for required mental health training for school personnel in Session Law 2020-7.

As was noted earlier, educational personnel are in one of the top three categories of professionals in North Carolina who most often report child abuse and neglect, which is not surprising given their daily proximity to children. North Carolina's child abuse and neglect reporting law contained in the NC Juvenile Code makes all individuals, not just certain professionals, mandatory reporters when they suspect child abuse or neglect.⁶⁹ Many states have laws that list certain categories of professionals and individuals as mandatory reporters (educational professionals would typically be in those categories) and those laws sometimes contain requirements related to training that mandatory reporters must complete.

During the 2020 legislative session, a law passed that required schools to adopt and implement a school-based mental health plan that includes a mental health training program to be provided to school personnel who work with students in grades kindergarten through 12 and addresses the following topics:

- a. Youth mental health
- b. Suicide prevention

c. Substance abuse prevention

d. Sexual abuse prevention

e. Sex trafficking prevention

f. Teenage dating violence

The reason that sexual abuse prevention and sex trafficking prevention are highlighted above is because both sex abuse and sex trafficking are subcategories of child abuse in the Juvenile Code under G.S. 7B-101(1). Thus, training that addresses sexual abuse prevention and sex trafficking prevention would logically include training about mandatory reporting laws that involve sexual abuse or sex trafficking. Session Law 2020-7 would be strengthened by clarifying that training on the Juvenile Code's requirements for mandatory reporting of suspected child abuse and neglect, which includes suspected sexual abuse or sex trafficking, should be required. This would ensure that school personnel are educated about the mandatory CAN reporter law under the NC Juvenile Code and provided with information on what to do if they suspect child abuse or neglect.

ADMINISTRATIVE ITEM: Administrative support for continued efforts to strengthen education and awareness surrounding child abuse and neglect reporting, including strengthening ongoing training for law enforcement that also supports an understanding of trauma and mental health; and training that is tailored for healthcare providers.

Progress has been made in strengthening education and awareness surrounding child abuse and neglect reporting, some of which was in response to Task Force administrative items addressing needed changes. However, much more can be done to ensure that the public as well as professionals most likely to encounter suspected child maltreatment understand not only their obligation to report

but also how to recognize and respond to suspicions of maltreatment. The Intentional Death Prevention Committee therefore seeks to continue this work and believes there should be a special focus on trainings tailored for healthcare providers and law enforcement.

⁶⁹ N.C.G.S. 7B-301. Although a new law, S.L. 2019-245, addresses reporting certain crimes against children to law enforcement, the focus of the Intentional Death Prevention Committee's work was on reporting under 7B-301. [The Child Fatality Task Force had no involvement in S.L. 2019-245.]

Recommendations and administrative efforts to prevent motor vehicle-related injuries and deaths to children

The leading cause of injury-related death among children in North Carolina is motor vehicle crashes. Among childhood injuries in North Carolina in 2018, motor vehicle crashes were the third leading cause of

hospitalizations and emergency department visits for those ages 0-17.⁷⁰ North Carolina ranks among the highest for all 50 states in terms of medical and work loss costs associated with motor vehicle crash deaths.⁷¹

LEGISLATIVE RECOMMENDATION: Support legislation that would require ignition interlocks for all DWI offenders.

Alcohol is involved in approximately one-fourth of all fatal crashes in North Carolina.⁷² In 2019, 348 people were killed in alcohol-related crashes in North Carolina. Nationally, of the 36,560 traffic fatalities in 2018, there were an estimated 10,511 people (29%) killed in alcohol-impaired-driving crashes where at least one driver had a blood alcohol concentration of .08 or higher.⁷³

Of traffic deaths among children ages 0 to 14 in 2018, 22% involved an alcohol-impaired driver.⁷⁴ About one-third of those arrested for impaired driving are repeat offenders.⁷⁵ One study showed that the average alcohol-impaired driver has driven under the influence of alcohol over 80 times before their first arrest.⁷⁶

Alcohol ignition interlocks are breath test devices installed in a motor vehicle to prevent operation of the vehicle by a driver who has a blood alcohol concentration over a pre-set low limit. Current North Carolina law makes ignition interlocks mandatory if the person's blood alcohol level is greater than .15 or if the

The CDC recommends mandating ignition interlocks for all DWI offenders, including first-time offenders, as a highly effective strategy to prevent repeat DWI-related offenses.

At least 34 states now require ignition interlocks for all DWI offenders, but North Carolina is not one of them.

While installed, ignition interlocks reduce repeat offenses for driving while intoxicated by about 70%.

person is a second or subsequent offender (the requirement relates to restoration of a license or obtaining a limited driving privileges after a conviction for driving while impaired).⁷⁷

The CDC recommends ignition interlocks as a highly effective strategy to prevent repeat driving while impaired (DWI) offenses while

⁷⁰ Injury and Violence Prevention Branch of the NC Division of Public Health.

⁷¹ Centers for Disease Control and Prevention. *Motor Vehicle Crash Deaths: Costly but Preventable*. www.cdc.gov/motorvehiclesafety/statecosts/index.html.

⁷² Injury and Violence Prevention Branch, NC Division of Public Health, data source: NC Department of Transportation 2019 Traffic Crash Facts.

⁷³ National Highway Traffic Safety Administration, 2018 Traffic Safety Facts, State Alcohol-Impaired Driving Estimates.

⁷⁴ National Highway Transportation Safety Administration, 2018 Traffic Safety Facts, Children

⁷⁵ National Highway Traffic Safety Administration (February, 1995). *Repeat DWI Offenders in the United States*.

⁷⁶ National Highway Traffic Safety Administration (February, 1995). *Repeat DWI Offenders in the United States*.

⁷⁷ N.C.G.S. 20-17.8 and 20-179.3.

installed and recommends that interlocks be mandated for *all DWI offenders, including first-time offenders*. At least 34 states now require ignition interlocks for all offenders, but North Carolina is not one of them. The North Carolina Executive Committee for Highway Safety, chaired by the Secretary of Transportation, approved a resolution in 2019 to support legislation in North Carolina to mandate ignition interlocks for all alcohol-impaired driving offenders.⁷⁸

While installed, ignition interlocks reduce repeat offenses for driving while intoxicated by about 70%.⁷⁹ One study found that state laws that mandate ignition interlocks for all drunk driving offenders were associated with a 7% decrease in the number of alcohol-involved (BAC 0.08) fatal crashes, whereas laws that apply to only a subset of DWI

offenders were associated with about a 2% reduction in alcohol-involved fatal crashes.⁸⁰

With North Carolina's current ignition interlock program, as with programs in most states, costs associated with the devices themselves are borne by the offender. For offenders who cannot afford the fees associated with an interlock sanction, a growing number of states have developed special indigent offender funds to help offset the costs, with sources for those funds coming from fees imposed on all DWI offenders, fees added to license reinstatement, or a charge added by vendors to their paying customer's fees.⁸¹ (Neither the Child Fatality Task Force nor the Unintentional Death Prevention Committee of the Task Force has made any specific recommendation related to addressing costs of interlock devices.)

CDC's Recommendation

Mandating interlocks for all offenders, **including first-time offenders**, will have the greatest impact.

The number of impaired (BAC \geq 0.08%) drivers in fatal crashes falls



3% when states require interlocks for repeat offenders only



8% when states require interlocks for repeat offenders and first offenders with high BACs



15% when states require interlocks for all DUI offenders, including first offenders

⁷⁸ This resolution is available on the NC DOT website: <https://connect.ncdot.gov/groups/echs/Documents/2019/Ignition%20Interlock%20Resolution.pdf>.

⁷⁹ Centers for Disease Control and Injury Prevention. Motor Vehicle Safety. *Increasing Alcohol Ignition Interlock Use*. www.cdc.gov/motorvehiclesafety/impaired_driving/ignition_interlock_states.html.

⁸⁰ McGinty et al, (April 1, 2017). Ignition Interlock Laws: Effects on Fatal Motor Vehicle Crashes, 1982 – 2013. *American Journal of Preventive Medicine*, Volume 52, Issue 4.

⁸¹ U.S. Department of Transportation, National Highway Traffic Safety Administration (February, 2014). *Ignition Interlocks – What You Need To Know: A Toolkit for Policymakers, Highway Safety Professionals, and Advocates*. www.nhtsa.gov/sites/nhtsa.dot.gov/files/documents/ignitioninterlocks_811883_0.pdf. North Carolina has an indigency application that may be filled out to determine eligibility for waiving installation on additional vehicles, see www.ncdot.gov/dmv/license-id/license-suspension/Pages/ignition-interlock-devices.aspx.

ADMINISTRATIVE ISSUE: Administrative support to continue efforts to gather information on the potential for future legislation that allows for primary enforcement of all unrestrained back seat passengers with the intent to bring this item back for consideration by the Unintentional Death Prevention Committee prior to the 2022 legislative session, and Governor's Highway Safety Program to work with the Driver Education Advisory Committee to educate about the importance of back seat restraints.

This item was a legislative support recommendation made by the Child Fatality Task Force from 2016–2019. While the Unintentional Death Prevention Committee of the Task Force considers this prevention strategy to still be important, the committee recommended for purposes of the 2020 and 2021 CFTF Action Agenda for this item to be administrative with continued gathering of information on this issue with the intent to bring this item back for consideration by the Committee prior to the 2022 legislative long session. For that reason, general information on this topic is provided below while more detailed information related to the recommendation made in prior years can be found in the CFTF 2019 Annual Report.⁸²

North Carolina law currently requires passengers in all positions of a vehicle to be restrained; however, failure to wear a seatbelt

in the back seat by those 16 and up cannot be justification for a traffic stop, so it is a “secondary enforcement” (as opposed to primary enforcement) offense.⁸³ According to the National Highway Traffic Safety Administration (NHTSA), primary enforcement seat belt laws lead to higher usage rates, and seat belt use is the most effective way to prevent fatalities and injuries in the event of a motor vehicle crash. Data clearly illustrates the dangers of passengers being unrestrained in the back seat, not only causing injury to the person who is unrestrained but to other passengers as well. NHTSA has formally urged North Carolina to close this gap in its passenger safety law.⁸⁴ In addition, the North Carolina Executive Committee for Highway Safety, chaired by the NC Secretary of Transportation and comprised of leading highway safety experts and stakeholders, approved a resolution in 2018 in support of this recommendation.

ADMINISTRATIVE ISSUE: Administrative support for continuation of a child passenger safety study by the Occupant Protection Task Force to bring information back to the Unintentional Death Prevention Committee for consideration prior to the 2022 legislative session.

The CFTF 2020 Action Agenda contained an administrative item for a child passenger safety study by an outside group to examine the status of North Carolina's child passenger safety laws in comparison to recommendations from the American Academy of Pediatrics (AAP) and the National Highway Safety Board. NC Child presented information from a preliminary study on this topic to the Unintentional Death Prevention Committee during its most recent study cycle. In addition, North Carolina's Occupant

Protection Task Force discussed the issue and shared additional data and analysis with the committee about current child passenger safety laws and potential changes to laws, noting that more data analysis is needed, and revised recommendations from the AAP are expected to be released soon. The committee therefore decided that further study of this topic by the committee is needed before determining whether to make any recommendations related to revisions of child passenger safety laws.

⁸² The CFTF 2019 Annual Report is available on the CFTF website.

⁸³ See N.C.G.S. 20-135.2A(d1) & (e); restraint of children under age 16 is according to G.S. 20-137.1.

⁸⁴ Occupant protection assessments for NC are conducted by the National Highway Traffic Safety Administration (NHTSA), and have resulted in the recommendation for primary enforcement of a mandatory seat belt law for all seating positions. In December, 2015, the National Transportation Safety Board sent a letter to former Governor McCrory urging enactment of legislation to accomplish this recommendation.

Recommendation to prevent harm to youth caused by tobacco and nicotine use

LEGISLATIVE RECOMMENDATION: Endorse at least \$7 million in funding for youth nicotine use prevention, including e-cigarettes.

Ninety percent of tobacco users start before the age of 18. From 2011 to 2017, current use of electronic cigarettes among North Carolina high school students jumped by 894%, from 1.7% to 16.9%. During the same time period, electronic cigarette use among middle school students increased 430%, from 1% to 5.3%. From 2017 to 2019, e-cigarette use among high school students increased an additional 24%. E-cigarettes contain liquids with nicotine that can be bought in thousands of flavors. Nicotine is highly addictive and can harm adolescent brain development; tobacco product use in any form, including e-cigarettes, is unsafe for youth.⁸⁷ Devices such as the very popular JUUL e-cigarette, that looks like a flash drive and delivers a high dose of nicotine, have a sleek design attractive to teens who use them for discreet vaping anywhere, including in school.

The U.S. Surgeon General, working with the Centers for Disease Control and the Food and Drug Administration, issued an advisory on youth use of e-cigarettes on December 18, 2018. This advisory called e-cigarette use among youth an epidemic based on the 2018 National Youth Tobacco Survey showing that e-cigarette use among high school students increased from



11.7% in 2017 to 20.8% in 2018. Additionally, the 2018 Monitoring the Future national high school study release showed the spike in e-cigarette use among youth in 2018 is the largest increase in youth drug use in 43 years — since 1975.

The funding being recommended by the Task Force (which would be directed to DHHS, DPH Tobacco Prevention and Control Branch) would support educational programs across North Carolina to reach young people with effective tobacco use prevention messages and programs, leadership training for peer-led and adult-supported tobacco use prevention programs, as well as educational materials and evaluation of data. The North Carolina Institute of Medicine's Healthy North Carolina 2030 report has targets to reduce youth tobacco use in North Carolina by 2030 through CDC's levers for change.⁸⁸

North Carolina's spending on tobacco use prevention has drastically decreased since 2012, despite receiving an average of \$149,825,874 per year since 2001 from the Tobacco Master Settlement Agreement and since that time, use of e-cigarettes by youth has increased dramatically.

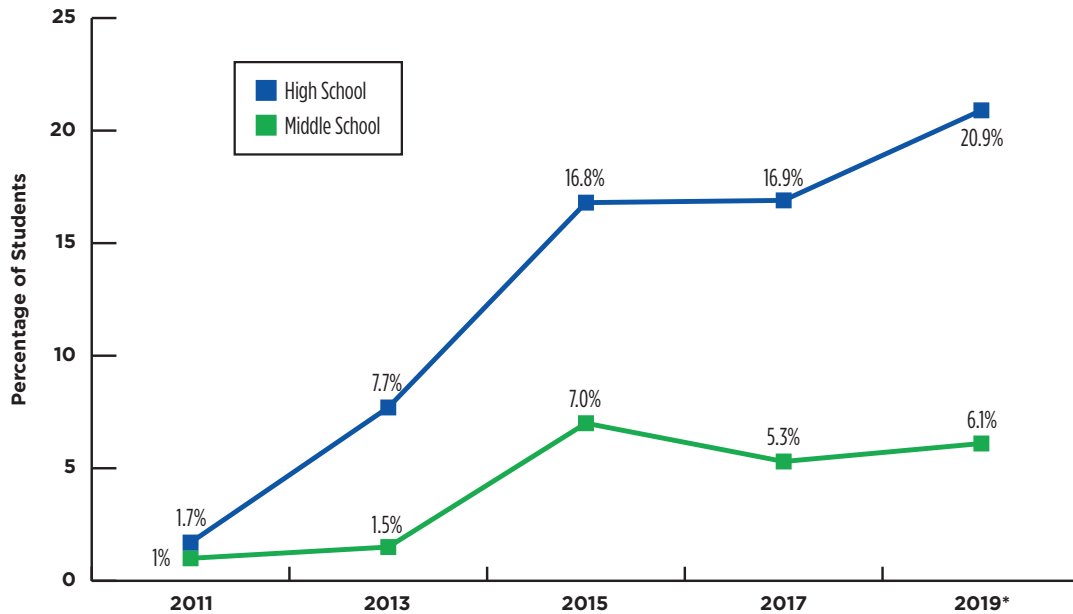
From 2011 to 2017, current use of electronic cigarettes among North Carolina high school students jumped by 894%, from 1.7% to 16.9%.

⁸⁷ U.S. Centers for Disease Control and Prevention.

⁸⁸ Healthy North Carolina 2030, North Carolina Institute of Medicine (February 18, 2020). See page 68. <http://nciom.org/healthy-north-carolina-2030-a-path-toward-health/>.

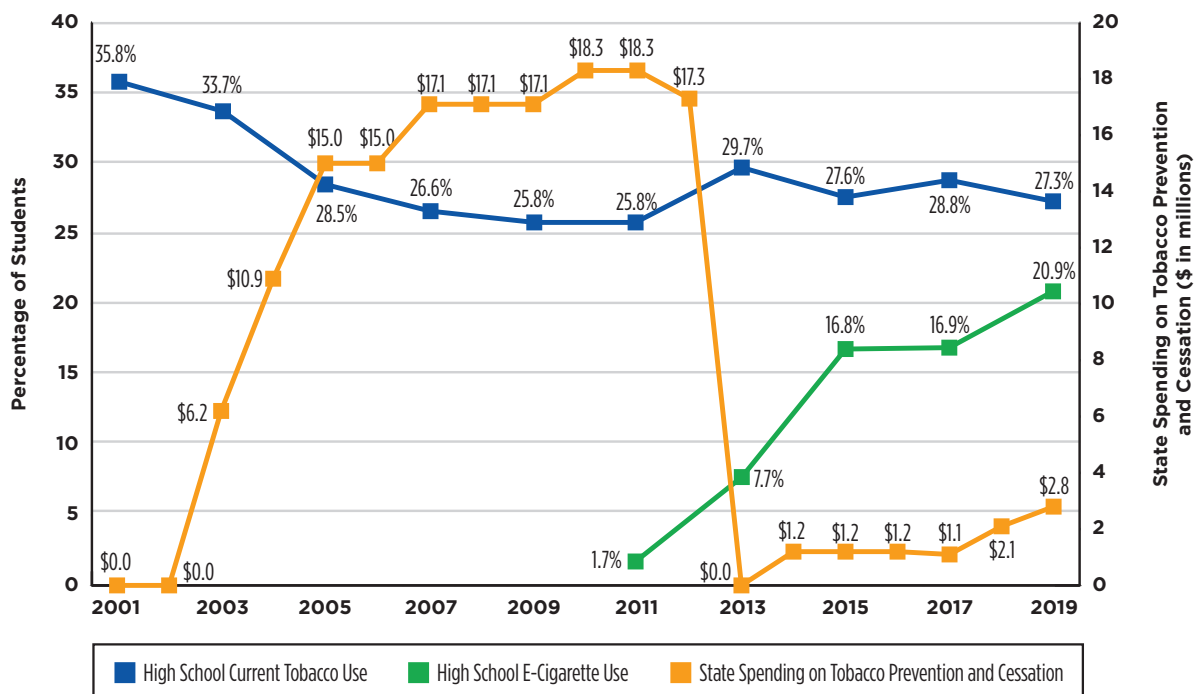
E-CIGARETTE USE AMONG HIGH SCHOOL STUDENTS CONTINUES TO INCREASE

PAST 30 DAY USE OF E-CIGARETTES, NC YTS



*2019 estimates may not represent the full population due to low response rate • Source: 2019 North Carolina Youth Tobacco Survey Results

HIGH SCHOOL TOBACCO USE AND STATE SPENDING ON TOBACCO USE PREVENTION AND CESSATION IN NORTH CAROLINA 2001-2019



Tobacco Master Settlement Funding for Tobacco begins in NC via HWTF 2002

Emergence of e-cigarette use among youth 2011

Since 2001, North Carolina has received an average of \$149,825,874 per year from the Tobacco Master Settlement Agreement



Legislative History *and* Accomplishments

Every year since its creation in 1991, the North Carolina Child Fatality Task Force has helped achieve legislative victories for children. The following list is organized by year and includes most — but not all — of the legislative accomplishments of the Child Fatality Task Force.

1991

North Carolina Child Fatality Task Force established. The Task Force, a diverse legislative study commission, was charged to study the incidence and causes of child death as well as to make recommendations for changes to legislation, rules, or policies that would promote the safety and well-being of children. The Task Force was also charged to develop a system for multi-disciplinary review of child deaths.

Community Child Protection Teams (CCPTs) established. CCPTs were established in each county by Executive Order. Each CCPT has the responsibility to review selected active Child Protection Services cases of the county Department of Social Services and review all cases in the county in which a child died as a result of suspected abuse and neglect. The purpose of these reviews is to identify gaps and deficiencies in the community child protection system and safeguard the surviving siblings.

North Carolina Child Fatality Review Team (State Team) established. The State Team, a multi-agency panel, was directed to review all cases of fatal child abuse, all deaths of

children known to Child Protective Services before their deaths, and additional cases of child maltreatment. The purpose of the reviews is to discover the factors contributing to child fatalities in North Carolina. The State Team is required to report to the Task Force and to recommend legislation to prevent child deaths.

1992

North Carolina Child Fatality Task Force membership expanded to include members of the General Assembly. Two Senators and two members of the House of Representatives, as well as one local health director, were appointed.

North Carolina Child Fatality Task Force extended to 1995.

Additional funds appropriated for Child Protective Service Workers. The Task Force requested \$5 million, with a plan to request a total of \$30 million over several years. The bill also called for a study of the financing of CPS positions in county Departments of Social Services. The General Assembly appropriated \$1 million.

Pilot programs for Family Preservation Services funded. The General Assembly appropriated \$410,000 for the Basic Social Services plan in three to five counties as pilots, and \$50,000 to develop and implement model programs of locally based Family Preservation Services.

Study of Child Protective Services funded. The General Assembly appropriated \$80,680 to conduct a study to determine a method that would ensure accountability by the county Child Protective Services programs, to ascertain the best management structure for Child Protective Services, and to determine the need for stronger state supervision of county programs.

“Hot Lines” established. The General Assembly appropriated \$62,000 to establish 24-hour Protective Services “hot lines” in each county.

Additional funds for the Child Medical Evaluation Program appropriated. The General Assembly appropriated \$935,750 for the Child Medical Evaluation program, \$180,000 of which was allocated for a backlog of claims for services and was non-recurring.

Protocols required. The legislation directed the DHHS Division of Social Services to ensure that community interdisciplinary teams develop protocols for use in child abuse and neglect reviews.

1993

Local Child Fatality Prevention Teams (CFPTs) established. Local CFPTs were directed to review all child deaths in each county unless the death was already under review by the local Community Child Protection Team (CCPT). Since each county now had two community-based teams, the local CFPT and CCPT were given the option of joining together or operating independently. The multi-agency membership for the local teams was established by state statute.

Child Fatality Task Force specifically charged to study the incidence and causes of child abuse and neglect.

Additional funds for Child Protective Services Workers appropriated. The General Assembly appropriated \$2 million, but maximum caseload standards were not established by statute.

Committee established to develop a payment plan for the evaluation of maltreated children. The resulting committee recommended funding regional maltreatment resource centers.

NCGA Chapter 7A revised. Changes include creating the duty to report and investigate child dependency as well as child abuse and neglect; requiring county Department of Social Services directors, upon receiving a report about a child’s death as a result of suspected child maltreatment, to ascertain immediately whether or not there are other children in the home; improving information sharing; and mandating child fatalities from alleged maltreatment be reported to the Division of Social Services Central Registry.

Driving While Impaired (DWI) law amended. The amended statute provides that the presence of a child under 16 years of age in a vehicle driven by a person convicted of a DWI violation shall be considered a grossly aggravating factor in sentencing.

Funding for student services personnel provided. The General Assembly appropriated \$10 million for school counselors, to fulfill a provision of the Basic Education Plan.

Comprehensive health screening for kindergarten students mandated. This law requires each child to have a comprehensive health screening evaluation by the time he or she enters kindergarten.

1994

Six additional members of the General Assembly appointed to the Task Force.

Three Senators and three members of the House of Representatives were appointed.

North Carolina Child Fatality Task Force extended to 1997.

Family Preservation Program expanded. The General Assembly appropriated \$500,000 to expand this program.

Prosecutorial child protection law passed.

This law provides for bail and pretrial release conditions determined by the judge in child abuse cases. It also provides for children to be made comfortable in courtrooms during child abuse cases.

Child passenger safety law strengthened.

This law requires children under 12 to be safely restrained while riding in a car, whether they sit in the front or the back seat. Infants and toddlers under age four must be secured in child safety seats; older children must use seat belts.

The following laws were passed during the Special Session on Crime called by the governor in 1994:

The Task Force supported several components of the governor's crime package of legislation that applied to juveniles: **Family Resource Centers, Wilderness Camps, the Mentor Training Program for Coaches, and the Governor's One-On-One Program.**

The Task Force worked to amend a bill calling for a comprehensive study of the Division of Youth Services' Juvenile Justice System. The amendment provided for **diagnostic assessments of all youth in state training schools** to determine that each youth has been properly placed.

Community-Based Alternatives program funded. The General Assembly appropriated \$5 million for programs that are intended to reduce the number of youths committed to training schools by rehabilitating these troubled youths in their communities.

The Task Force also worked to increase **the penalty for illegally selling guns to a minor from a misdemeanor to a felony.** This felony charge for a weapons violation enables law enforcement to aggressively prosecute those who illegally sell firearms to minors.

1995

Training for child sexual investigations initiated.

The Task Force requested \$125,000 for statewide, multidisciplinary training for child sexual abuse investigations. The training was funded for \$38,336 recurring and \$5,000 non-recurring funds through the State Bureau of Investigation.

Underage drinkers prohibited from driving.

The Task Force endorsed legislation requiring "zero tolerance" for alcohol measured in the blood or breath of drivers 18–20 years old.

Smoke detectors required in all rental property.

This law filled in a gap in North Carolina's smoke detector laws by requiring landlords to install operable smoke detectors for every dwelling.

Sale of fireworks to children prohibited. Before 1993, the sale of pyrotechnics was illegal in North Carolina. In 1993, the General Assembly allowed the sale of some pyrotechnics. The Task Force sought to repeal these changes to the pyrotechnics law in 1995. The General Assembly did not repeal the 1993 law, but a bill was passed that restricts the sale of those pyrotechnics to individuals over the age of 16.

Adoption proceedings moved from Superior to District Court. The Task Force sponsored this legislation as a first step toward creating a comprehensive family court system in North Carolina.

1996

Child abduction law strengthened. This law applies the penalty for abducting a child from a parent, guardian, or school or abductions from any agency or institution lawfully entitled to the child's custody.

1997

Dependent juvenile definition changed. The old statute defined a juvenile as dependent if his or her parents were unable to provide care “due to physical or mental incapacity.” This language did not make provision for other situations, such as one in which one or both parents are incarcerated. This law broadened the definition of dependent juvenile and enabled hundreds more children to receive help from the county Departments of Social Services.

Intensive Home Visiting partially funded. The Task Force had a standing goal of encouraging the state to appropriate \$3.2 million for intensive home visiting programs shown to be effective in reducing the incidence of child abuse and neglect, unwanted pregnancy, and juvenile involvement with the courts. In 1997, the General Assembly appropriated \$825,000 for home visiting, with an additional \$200,000 in 1998.

Graduated Driver’s License mandated. This measure gives new teenage drivers more experience — and a greater chance of survival — as the result of a three-step process for obtaining a driver license. This ensures beginning drivers get a full year of supervised practice driving with a parent. It also restricts night-time driving for new licensees during the first six months of unsupervised driving.

1998

Sunset of the Task Force lifted.

Court Improvement Project launched. To reduce the amount of time that children are in foster care, the Task Force supported legislation to change the process for handling abuse and neglect cases. As a result of this legislation, termination of parental rights may now be a motion in the cause, adjudication must take place within 60 days of the filing of the petition, the first hearing must be at 90 days, and the second hearing within six months.

Smoke detector penalty set. This law sets a \$250 penalty for landlords who fail to install smoke detectors in rental units and a \$100 penalty for tenants who destroy or disable smoke detectors after they have been installed.

1999-2000

Child passenger safety law strengthened. The passage of Senate Bill 1347 will save an estimated five lives and 45 serious injuries among child passengers aged 16 or younger each year. The new law imposes a two-point driver’s license penalty on drivers who do not see that young passengers are in age-appropriate safety restraint. The enactment of this law closes one of the last remaining gaps in the state’s motor vehicle passenger safety laws.

Juvenile procedures clarified. Passage of House Bill 1609 will help move children from abusive, dangerous environments toward safer, permanent homes. The old law required that parents be given separate notices of the possible termination of their parental rights, even if termination is clearly best for the child. This measure streamlines the legal process while preserving parents’ rights to proper notification.

Guardianship strengthened. Sometimes called “soft adoption,” guardianship is a good option for some children who need a safe, nurturing home. Passage of Senate Bill 1340 clarifies the rights and duties of a legal guardian and thereby creates a more stable home for children with court-appointed guardians.

2001

Infant Homicide Prevention Act passed. House Bill 275 created a safe haven for newborns who would otherwise be abandoned by their distraught mothers.

Child Bicycle Safety Act passed. House Bill 63 established that bicycle riders age 15 and younger must wear an approved helmet when riding on public roads and rights-of-way.

Child Fatality Task Force 10-Year

Anniversary celebrated. In the 10 years of the Task Force's existence, the child death rate in North Carolina dropped approximately 20%. At 76.4 deaths per 100,000 children, North Carolina experienced the lowest child fatality rate it had ever recorded.

2002

"Kids First" license tags issued. The General Assembly and the Division of Motor Vehicles authorized and issued "Kids First" license tags with the proceeds going to the North Carolina Children's Trust Fund.

Key programs continued. During a time of intensive budget cuts, the Intensive Home Visiting program, the Healthy Start Foundation, the folic acid campaign, and the birth defects monitoring program all received continued funding.

Graduated Driver Licensing system improved. A provision was added to the existing system which limits the number of passengers under age 21 that a novice driver may transport during the first six months of unsupervised driving (allowing only one young, non-family member).

2003

Safe Surrender supported. Task Force members lent their support to the Division of Public Health who was successfully awarded a grant from the Governor's Crime Commission for FY 2003 - 2004 to increase public awareness of the Infant Homicide Prevention Act (aka NC Safe Surrender Law).

2004

NC Booster Seat Law (Senate Bill 1218) ratified. The law established that a child less than 8 years of age and less than 80 pounds in weight shall be properly secured in a weight-appropriate child passenger restraint system.

In vehicles equipped with an active passenger-side front air bag, if the vehicle has a rear seat, a child less than 5 years of age and less than 40 pounds in weight shall be properly secured in a rear seat, unless the child restraint system is designed for use with air bags. If no seating position equipped with a lap and shoulder belt to properly secure the weight-appropriate child passenger restraint system is available, a child less than 8 years of age and between 40 and 80 pounds may be restrained by a properly fitted lap belt only.

Endorsed. The Task Force endorsed strengthening penalties when methamphetamine is manufactured in a location that endangers children.

2005

All-Terrain Vehicle Safety Law (Senate Bill 189) ratified. The law established that a child less than 8 years of age is not allowed to operate an ATV. In addition the law creates restrictions based on age and machine size for children between the ages of 8 and 16. The law also requires adult supervision for children under 16, restricts passengers to those ATVs designed for more than one person, bans operation on public streets, roads and highways, and outlines equipment standards for sellers and buyers. In addition, safety training is now required for operators, as is the use of safety equipment.

2006

Unlawful Use of a Mobile Phone Law (Senate Bill 1289) ratified. The law established that children under the age of 18 cannot operate a motor vehicle while using a mobile phone or any technology associated with mobile phones. Exceptions were created for teens talking with their parents, spouses, or emergency personnel.

Rear Passenger Safety Law (Senate Bill 774) ratified. The law requires use of rear-seat safety belts by all passengers of non-commercial vehicles.

Strengthen Sex-Offender Registry

Law (House Bill 1896) ratified. The law strengthened North Carolina's existing sex offender registry system by requiring additional standards for monitoring sex offenders, including extensive monitoring of the most predatory offenders upon their release from prison.

Funds to Prevent Child Maltreatment

(Senate Bill 1249) appropriated. \$90,000 in recurring funds was allocated to the NC Department of Health and Human Services for one position to staff the Child Maltreatment Leadership Team and carry forth recommendations of the North Carolina Institute of Medicine's Task Force on Child Abuse Prevention.

General Statute 7B-302 DSS Disclosure of Confidential Information (Senate Bill 1216)

amended. The amendment clarified the ability of county Departments of Social Services to share confidential information with other professional entities. The amendment also put North Carolina in compliance with federal child welfare funding guidelines and allowed for continued federal support.

Funds to Prevent Preterm Births (Senate Bill 1741) appropriated. \$150,000 in non-recurring funds was allocated to provide medications to low-income women at-risk of a second premature birth. The medication is proven to reduce recurring preterm births by 33%.

Funds to establish a Perinatal Health

Network (Senate Bill 1253) appropriated. \$75,000 in non-recurring funds was allocated for the creation of a professional perinatal health network. The network will bring together perinatal health leaders to plan strategically for the reduction of infant mortality and promotion of women's and infants' health in North Carolina.

Endorsed. The Task Force endorsed: 1) continuing the Medicaid Family Planning Waiver; 2) recurring funding of the North Carolina Folic Acid Campaign at \$300,000; 3) recurring funding for the North Carolina

Healthy Start Foundation for statewide infant mortality reduction initiatives and conversion of non-recurring funding to recurring funding status; 4) recurring funding for the North Carolina Birth Defects Monitoring Program at \$325,000.

Administrative changes recommended.

1) support the DHHS Division of Public Health efforts to procure grant funds for youth suicide prevention; 2) form a CFTF subcommittee to work on gun safety, specifically pursuing a gun safety awareness campaign, creating talking points on gun safety, and seeking common ground to prevent injury and death to children and youth due to firearms.

2007

Child Passenger Safety Exemption (Senate

Bill 23) ratified. Amended § 20-317.1. (Child restraint systems required), by removing exemption (b)ii "when the child's personal needs are being attended to" in order to qualify North Carolina for the continuation of \$1 million in child passenger safety funding from the National Highway Traffic Safety Administration.

Funds to address infant deaths secured.

Appropriations recommended by the Child Fatality Task Force were secured and included \$97,000 in non-recurring funds to prevent preterm births by providing the medication known as 17-Progesterone to uninsured women and \$150,000 in non-recurring funds for a statewide Safe Sleep awareness campaign.

Endorsed. The Task Force endorsed:

1) \$200,000 in recurring funds were provided for the birth defects monitoring system; 2) \$150,000 in non-recurring funds were provided for the North Carolina Healthy Start Foundation; 3) the Fire Safe Cigarette Act (House Bill 1785) passed and requires cigarette manufacturers to produce and market only cigarettes that adhere to an established cigarette fire safety performance standard.

Legislative charge received. Senate Bill 812 directed the Child Fatality Task Force to study issues relating to requiring the installation and use of passenger safety restraint systems on school buses and report findings by May 2008.

2008

Amend Child Abuse (Senate Bill 1860)

ratified. An act to increase the criminal penalty for misdemeanor child abuse and to amend the criminal offense of felony child abuse.

Hospital Report Child Injuries (House Bill 2338) ratified.

An act to require hospitals and physicians to report serious, non-accidental trauma injuries in children to law enforcement officials.

Funds to prevent preterm births provided.

\$97,000 in non-recurring funds appropriated to continue efforts to provide minority and low-income women at-risk for delivering a premature infant with a preventative treatment to reduce the risk of a recurring preterm birth.

Funds to reduce infant deaths secured.

\$150,000 in non-recurring funds appropriated to continue funding for a statewide public awareness campaign to promote safe sleep and reduce infant deaths due to Sudden Infant Death Syndrome (SIDS) and unintentional suffocation/strangulation.

Child Passenger Safety Technician Liability (House Bill 2341) ratified.

An act to limit liability for the acts of certified child passenger safety technicians and sponsoring organizations of child safety seat educational and checking programs when technicians and sponsoring organizations are acting in good faith and child safety seat inspections, installation, adjustment or education programs are provided without fee or charge.

Require Carbon Monoxide Detectors (Senate Bill 1924) ratified.

An act to authorize the North Carolina Building Code Council to adopt provisions in the Building Code pertaining to

the installation of carbon monoxide detectors in certain single-family or multifamily dwellings; to require the installation of operational carbon monoxide detectors in certain residential rental properties and to provide for mutual obligations between landlords and tenants regarding the installation and upkeep of carbon monoxide detectors.

Transporting Children in Open Bed of Vehicle (House Bill 2340) ratified.

An act to increase the protection of children who ride in the back of pickup trucks or open beds of vehicles by raising the minimum age to 16 and removing the exemption that made allowances for small counties.

Change Format of Driver Licenses/Under 21 (House Bill 2487) ratified.

An act to change the format of a driver license or special identification card being issued to a person less than 21 years of age from a horizontal format to a vertical format to make recognition of underage individuals easier for clerks dealing in restricted age sales of products such as alcoholic beverages and tobacco products.

2009

Funding to prevent preterm births provided.

\$97,000 in non-recurring funds appropriated to continue efforts to provide minority and low-income women at-risk for delivering a premature infant with a preventative treatment to reduce the risk of a recurring preterm birth.

Funding to reduce infant deaths provided.

\$150,000 in non-recurring funds appropriated to continue funding for a statewide public awareness campaign to promote safe sleep and reduce infant deaths due to Sudden Infant Death Syndrome (SIDS) and unintentional suffocation/strangulation.

The Division of Medical Assistance directed to explore interconceptional care.

This direction allows DMA to pursue a federal waiver or other mechanism to offer a basic package of interconceptional care services to low-income women at high-risk for delivering prematurely.

Funding continued for Child Medical Evaluation System. This system provides diagnostic services to children suspected of being victims of child maltreatment.

Interagency agreements established to better protect children from violent sex offenders. The federal Adam Walsh Child Protection and Safety Act requires a more comprehensive, nationalized system for registration of sex offenders. To meet this goal, interagency collaboration has been established between the State Bureau of Investigation, the Sheriff's Association, the Division of Social Services and others.

An Act to Prohibit the Retail Sale and Distribution of Novelty Lighters (Senate Bill 652) ratified. This act to protect children by banning the sale of novelty lighters.

The Nicholas Adkins School Bus Safety Act (House Bill 440) ratified. This measure assures that pictures taken of drivers committing a stop arm violation are acceptable evidence for conviction and makes it a felony if a student is killed due to an illegal pass of a stopped school bus.

Youth employment protections passed. Enhance Youth Employment Protection Act (H22) enhances reporting and surveillance requirements by the Department of Labor. Strengthen Child Labor Violation Penalties (H23) increases penalties to employers who violate child labor requirements.

2010

Funding to preserve infant mortality prevention infrastructure maintained. Due to on-going state budget constraints, the Task Force focused on maintaining a package of services that works together to help babies be born healthy and to make it to their first birthday. Elements of the package include the following: \$350,000 for the NC Folic Acid/Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; \$325,000 for the Eastern

Carolina University High-Risk Maternity Clinic to improve birth outcomes in Eastern North Carolina; \$150,000 for Safe Sleep to avoid SIDS and other sleep-related deaths; \$97,000 for 17-Progesterone distribution to help prevent pre-term births; \$408,000 for the Healthy Start Foundation to improve maternal health prior to and during pregnancy.

Increase Driver's License Restoration Fee (\$655) ratified. This act increases the fee that drivers who have their licenses suspended following conviction for impaired driving must pay to have their licenses later restored. All funds raised (an estimated \$560,000 each year) will go to Forensics Tests for Alcohol to continue programs to deter, detect, and convict impaired drivers.

2011

Funding to preserve infant mortality prevention infrastructure maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that works together to help babies be born healthy and to make it to their first birthday. Elements of the package include the following: \$350,000 for the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; \$150,000 for Safe Sleep to avoid SIDS and other sleep-related deaths; \$47,000 for 17-Progesterone distribution to help prevent pre-term births. These items were funded nonrecurring out of the Maternal and Child Health Block Grant.

Fine for speeding in a school zone increased to \$250 (\$49). Speeding just an extra 10 mph in a school zone greatly increases the chance of death for a student hit by a car. The chance of pedestrian death increases nine-fold (from 5% to 45%) with an increase in speed from 20 mph to 30 mph. This bill makes the fine for speeding in a school zone equal to that of speeding in a construction zone.

Sale of certain dangerous synthetic substances banned (\$7). This act bans substances previously available legally —

including a synthetic cannabinoid that produces a marijuana-like high and MDPV, a synthetic that produces a cocaine-like high and hallucinations. The ban went into effect June 1, 2011. Throughout the early implementation period, the CFTF has worked with law enforcement and others to monitor the effectiveness of the ban.

Penalty for driving impaired with a child in the car enhanced (S241). Motor vehicle crashes are the leading injury-related cause of death for children and impaired driving is a factor in 15% -20% of those deaths. National data show that most children who die in crashes where alcohol is involved are the passenger of the impaired driver. Additionally, impaired drivers are also less likely to buckle-up their children safely.

Concussion protocols established (The Gfeller-Waller Athletic Concussion Awareness Act -H792). This act requires that coaches, other school personnel, and parents of middle and high school athletes receive information about concussions and prohibits same-day return-to-play. Only once cleared for play by specified health providers may athletes later return to practice or play.

Changes to the graduated driver licenses system monitored. Since North Carolina adopted graduated driver licensing, crashes are down 38% for 16-year-olds and 20% for 17-year-olds, among the best results of any state. Time spent driving and gaining experience is critical for teens learning to drive more safely. Changes from Modify Graduated Licensing Requirements (S636) include requiring learning drivers keep a log of time and conditions driven. Additionally, a provisional license will be revoked if the licensee is charged with a variety of serious driving violations, such as excessive speeding. The Division of Motor Vehicles is charged with evaluating the effectiveness of the provisions.

Endorsed. The Perinatal Quality Collaborative of NC received \$250,000 in funding (from the Maternal and Child Health Block Grant).

2012

Funding to preserve infant mortality prevention infrastructure partially maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that works together to help babies be born healthy and to make it to their first birthday. Elements of the package include the following: \$350,000 for the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; \$375,000 to the East Carolina University High-Risk Maternity Clinic; and \$47,000 for 17-Progesterone distribution to help prevent pre-term births. These items were funded nonrecurring out of the Maternal and Child Health Block Grant. However, funding for Safe Sleep and the NC Healthy Start Foundation were eliminated.

Replacement of conventional smoke alarms with tamper-resistant lithium-battery alarms in rental units (S77). Over the past five years, 75 children and hundreds of adults have died due to fire. Fire and flame are the fourth leading cause of death of North Carolina children ages 5 to 9. Furthermore, national data reveal that two-thirds of fire deaths occur in homes without an operating smoke alarm, often because the battery has been removed or is not working. The new science of tamper-resistant lithium battery alarms can help solve this problem since alarms with these batteries work for 10 years and the batteries cannot be removed for other uses. This measure requires landlords to phase-in tamper-resistant lithium battery units as conventional battery units are scheduled for replacement.

Funding to preserve evidence-based treatment programs for children maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that works together to help screen and treat at-risk children: Funding was maintained at flat levels, often with federal funds, for the Child Medical Evaluation Program, Child Advocacy Centers, the Child Treatment Program, and suicide gatekeeper programs.

Endorsed. The Perinatal Quality Collaborative of NC received \$250,000 in funding (from the Maternal and Child Health Block Grant). A bill (H176) passed addressing concerns on tracking of domestic violence cases to make more clear when “assault on a female” (or other crimes) occur between intimate partners or strangers. In addition to improving data and understanding of ways to address problems, this may help workers within the Division of Social Services have more complete information on when domestic violence is a factor in the home. Smoking cessation and prevention was funded at \$2.7 million from the Social Services Block Grant.

2013

Revise Controlled Substance Reporting

(S222). Poisoning is the fastest growing cause of teen death. The bill made changes to the Controlled Substance Reporting System (CSRS) to deter pill mills, to make it easier for doctors to check to see previous prescription-fill history to avoid duplicate prescriptions and to offer treatment as needed, to provide more timely data, and to allow data tracking relating to atypical prescribing or filling, as well as other provisions.

Require Pulse Oximetry Screening (S98).

Pulse oximetry is a quick and inexpensive test that screens newborns for certain congenital heart disease. If the baby is sent home before this condition is detected, the baby may get very sick and need to be rushed to the hospital for emergency surgery. Pulse oximetry screening allows timely, non-emergency intervention that can save lives.

Health Curriculum/Preterm Birth (S132).

Prematurity is one of the leading causes of infant deaths. This bill incorporates into the Healthy Behaviors Curriculum information about the preventable risks of preterm birth including induced abortion, smoking, alcohol consumption, the use of illicit drugs, and inadequate prenatal care.

Funding to preserve infant mortality prevention infrastructure partially maintained.

Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that work together to help babies be born healthy and to make it to their first birthdays. Elements of the package include the following: the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; East Carolina University High-Risk Maternity Clinic to treat high-risk pregnancies in the eastern part of the state; 17-Progesterone distribution to help prevent pre-term births; NC Healthy Start Foundation to provide community-based organization with evidence-based strategies and communications to improve the health of women of reproductive age and their babies; the Perinatal Quality Collaborative to promote best practices with hospitals; the Safe Sleep Campaign to promote safe sleep including in hospitals; and You Quit Two Quit to provide training assistance to help medical practices implement evidence-based protocols to reduce smoking by pregnant women. ECU was funded recurring with state funds. Other funded items were funded nonrecurring out of the Maternal and Child Health Block Grant. However, no funding was provided for the Healthy Start Foundation or You Quit Two Quit tobacco cessation for women.

Funding for Child Treatment Program.

The Child Treatment Program (CTP) is an evidence-based treatment for children who have experienced trauma. The CFTF supported funding of \$2 million for an implementation platform to assure the treatment was used statewide with fidelity. Funding was included in the budget.

Funding for services to stabilize families and prevent children from being removed from their homes.

Changes in federal funding resulted in loss of \$12 million to the Division of Social Services for services to help keep children at-risk of abuse or neglect safe in their own homes. Funding of \$4.8 million was provided.

Endorsed. Funding for Child Advocacy Centers and the Child Medical Evaluation Program; measures to make it easier for doctors to prescribe and third parties to use a medication (naloxone) to reverse drug overdoses (S20).

2014

Funding to preserve infant mortality prevention infrastructure partially maintained.

The CFTF continued to focus on maintaining a package of services that work together to help babies be born healthy and to make it to their first birthdays. Elements of the package include the following: the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; East Carolina University High-Risk Maternity Clinic to treat high-risk pregnancies in the eastern part of the state;17-Progesterone distribution to help prevent pre-term births, NC Healthy Start Foundation to provide community-based organization with evidence-based strategies and communications to improve the health of women of reproductive age and their babies, the Perinatal Quality Collaborative to promote best practices with hospitals, the Safe Sleep Campaign to promote safe sleep including in hospitals, and You Quit Two Quit to provide training assistance to help medical practices implement evidence-based protocols to reduce smoking by pregnant women. ECU was funded recurring with state funds. Other funded items were funded nonrecurring out of the Maternal and Child Health Block Grant. However, no funding was provided for the Healthy Start Foundation or You Quit Two Quit tobacco cessation for women. A special budget provision allows programs that provide tobacco cessation services for pregnant women and new mothers to apply for a certain competitive grant process.

Funding for services to stabilize families and prevent children from being removed from their homes. Changes in federal funding resulted in a loss of \$12 million to the Division

of Social Services for services to help keep children at-risk of abuse or neglect safe in their own homes. Funding of at least \$9 million was provided.

Coverage of lactation support through the

Division of Medical Assistance: Given the strong cost savings and lifesaving benefits of breastfeeding, DMA was authorized to reimburse costs associated with lactation consultants. (Initially, legislation was sought, but it was later determined to be unnecessary.) This is estimated to save 14 to 18 infant lives per year.

Endorsed. Funding for Child Advocacy Centers and the Child Medical Evaluation Program; authorization of the NC Department of Environment and Natural Resources (now known as the NC Department of Environmental Quality) to participate in the Interstate Chemicals Clearinghouse for the purposes of access to key data necessary to enhance safety in use of toxic chemicals.

2015

A new law protecting children from nicotine poisoning:

North Carolina became one of the first states to prohibit the sale of e-cigarette liquid containers without child-resistant packaging and without labeling those that contain nicotine. This protects small children who may access liquid nicotine (often sold in candy or fruit flavors) resulting in exposure that may cause injury or death. Calls to Carolinas Poison Centers related to liquid nicotine have risen dramatically in recent years, going from eight calls in 2011 to 137 calls in 2014.

A new law protecting children from skin cancer:

The “Jim Fulghum Teen Skin Cancer Prevention Act” prohibits tanning bed operators from allowing individuals under age 18 to use their tanning equipment. With melanoma rates in North Carolina higher than the national average and studies showing the majority of melanoma cases in young adults are connected to indoor tanning bed use, the purpose of this measure is to reduce the incidence of skin cancer.

Measures to address prescription drug misuse and poisoning: Approximately one in five high school seniors in North Carolina reports having taken prescription drugs without a prescription. Medications are among the most common type of exposure prompting calls to Carolinas Poison Control Center regarding children and adolescents. The CFTF recommended funding for safe drug disposal (Operation Medicine Drop) to decrease access to drugs that can result in misuse or poisoning, and this item was funded as non-recurring. The CFTF endorsed the reinstatement of funding for Carolina's Poison Control Center, which was funded as recurring, and also endorsed measures to strengthen the Controlled Substances Reporting System, resulting in a number of improvements to the system.

Endorsed: Funding to preserve infant mortality prevention infrastructure: The CFTF focused on maintaining a package of services that works together to help babies be born healthy and make it to their first birthday, including funding for the following: East Carolina University High-Risk Maternity Clinic to treat high-risk pregnancies in the eastern part of the state; 17-Progesterone distribution to help prevent pre-term births; the Perinatal Quality Collaborative (PQCNC) to promote best practices with hospitals; the Safe Sleep Campaign to promote safe sleep; and the NC March of Dimes Preconception Health Campaign to decrease birth defects and improve birth outcomes. ECU and PQCNC were funded with state funds. Other items were funded out of the Maternal and Child Health Block Grant.

Endorsed: Funding to support accredited Child Advocacy Centers in North Carolina who provide services for abused children by bringing together local child protective services, law enforcement, prosecutors, and medical and mental health providers. The CACs were funded with nonrecurring state funding and maintained block grant funding.

2016

Funding for perinatal tobacco cessation and prevention: Tobacco use during pregnancy is directly associated with the top four causes of infant mortality in North Carolina. The goal of You Quit Two Quit Program, which received \$250,000 in nonrecurring funds, is to ensure there is a comprehensive system in place for high quality screening and treatment for tobacco use in women, including pregnant and postpartum mothers.

Funding for safe drug disposal: Operation Medicine Drop, which received \$120,000 in nonrecurring funds, is a nationally recognized North Carolina program that uses drug take-back events and permanent medicine drop boxes to collect 15 to 20 million doses of unused medications each year. Safe disposal of medications is one tool to address a current epidemic of prescription drug misuse and drug overdose by reducing access to drugs, particularly by small children and teens who often obtain drugs from friends and family.

A new law prohibiting unlawful transfer of custody of a child: This legislation is aimed at preventing child maltreatment, including situations where a parent or guardian feels unable or unwilling to care for his or her child and locates a stranger, for example over the internet, who takes physical custody of the child. Such unlawful transfers can result in children ending up in abusive or neglectful homes or in human trafficking rings. [Session Law 2016-115]

Change in CSRS law to facilitate research and education: The Controlled Substances Reporting System (CSRS) is an important tool in North Carolina's battle to understand and react to the current opioid overdose epidemic. Prior to this technical change, the law required CSRS data purging at six years, preventing epidemiologists and researchers from doing effective longitudinal evaluation and analysis of the CSRS system and trends. This change to the law requires quarterly purging of data more than six years old,

but instead of permanently discarding the data, it will now be maintained in a separate database so it can be used for statistical, research, or educational purposes.

Endorsed: Funding to support Children's Advocacy Centers in North Carolina. Children's Advocacy Centers provide services for abused children by bringing together local child protective services, law enforcement, prosecutors, and medical and mental health providers. The CAC model is an evidence-based national model with multiple proven benefits for children.

Monitored and maintained: Funds provided to the following perinatal health programs previously supported by the Child Fatality Task Force remained unchanged in the 2016 budget: Perinatal Quality Collaborative NC; East Carolina University High Risk Maternity Clinic; March of Dimes Preconception Health Campaign; 17-Progesterone; Safe Sleep Campaign.

2017

Recurring funding for perinatal tobacco cessation and prevention: Tobacco use during pregnancy is directly associated with the top four causes of infant mortality in North Carolina. The 2017 legislative budget contained \$500,000 in recurring funds for both the You Quit Two Quit Program and QuitlineNC, both of which can help prevent tobacco use during pregnancy.

Recurring funding to the Child Medical Evaluation Program: A Child Medical Evaluation (CME) is a specific evaluation performed by a qualified medical expert for neglect, physical abuse, or sexual abuse when it is suspected that a child is being abused or neglected by their parent. Evaluations are requested and findings are used by local departments of social services and medical professionals to determine a course of medical treatment for the child. An increase in recurring funds (\$723,000 per year) was needed in order to bring the reimbursement

rate for CMEs in North Carolina to the regional average rate of \$575. Prior to this increase, CMEs in North Carolina had been reimbursed a flat fee payment of \$250 for suspected sexual abuse and \$150 for other types of suspected maltreatment, putting North Carolina at risk of losing these specialized professionals for this important work requiring extensive hours and a high degree of expertise.

CFTF was one of many seeking strengthened tools for combating the opioid epidemic:

In 2017, a major piece of legislation called the "STOP Act" (Strengthen Opioid Misuse Prevention Act) containing numerous provisions addressing strategies for preventing opioid misuse passed the legislature unanimously (S.L. 2017-74). Many organizations and individuals were involved in advancing the STOP Act and although the CFTF was not primarily responsible, some of the STOP Act provisions aligned with 2017 CFTF Action Agenda recommendations: the STOP Act includes mandatory use of the Controlled Substances Reporting System by the medical profession (the Task Force recommended increased use of CSRS by medical professions); the STOP Act made a technical correction in the law to enable interstate data sharing for the Controlled Substances Reporting System (a recommendation by the CFTF); the STOP Act removed some barriers and provided funding for the Harm Reduction Coalition to continue its important work (the CFTF endorsed the efforts of the Harm Reduction Coalition to continue its work fighting the opioid epidemic).

Endorsed: Legislation authorizing civil penalties for passing a stopped school bus and the utilization of school bus cameras to facilitate automatic civil enforcement. [S.L. 2017-188]

Monitored and maintained: Funds provided to the following perinatal health programs previously supported by the Child Fatality Task Force remained unchanged in the 2017 budget: March of Dimes Preconception Health Campaign, 17-Progesterone, and the Safe Sleep Campaign. The CFTF had been

monitoring implementation of the child welfare case management system as part of NC FAST and the 2017 legislative budget contained funding for this purpose.

Child Fatality Prevention System Summit held on April 9 and 10, 2018 in Raleigh.

Although not a legislative event, this was a first-of-its-kind historic event during which Child Fatality Prevention System professionals from across the state came together to learn from state and national experts, share best practices and challenges, and take part in launching state and local initiatives focused on strengthening the CFP System and creating safer and healthier communities for North Carolina's children. The idea for the summit originated with the Executive Committee of the Task Force, which received support from the full Task Force for advancing plans for the Summit.

2018

Legislation passed to require a study of maternal and neonatal risk-appropriate care at health care facilities across North Carolina. This legislation requires NCDHHS to study the current status of North Carolina delivering hospitals related to capabilities for handling various complexity levels of care for mothers and newborns. The study is to identify disparities, service gaps, and other issues, and to make recommendations to ensure quality care in risk-appropriate facilities. This study is aimed at ensuring newborns and their mothers can access timely, comprehensive medical services from a medical facility able to meet their specific medical needs. [Session Law 2018-93]

Legislation passed to add three conditions to the state's newborn screening program:

Pompe (Glycogen Storage Disease Type II), MPS-I (Mucopolysaccharidosis Type I), and X-ALD (X-linked Adrenoleukodystrophy). Early detection of these conditions can lead to early treatments that can prevent

or improve many of the effects of these conditions, including prevention of early death. This legislation was addressed in the 2018 budget bill, Session Law 2018-5. The March of Dimes was a significant partner in this work.

School safety grant funding that includes CALM (Counseling on Access to Lethal Means) among the programs for which grants may be used.

As part of its work on suicide prevention and addressing access to lethal means, the 2018 CFTF Action Agenda included a recommendation to expand the use of the CALM program in North Carolina. This program is designed to train practitioners (medical, mental health) and others to implement strategies to help those who are deemed at risk for suicide by enlisting the help of their families and supportive others to reduce their loved ones' access to lethal means, particularly firearms. The 2018 budget bill, Session Law 2018-5, included \$3 million of funds directed to the Department of Public Instruction to be used for nonrecurring school safety grants to community partners to provide training to help students develop healthy responses to trauma and stress. CALM was included among several trainings designated in the budget bill as being suitable for these grants.

Some funding to add school nurses: As part of its suicide prevention work, the CFTF had recommended \$5 million in recurring funds to expand the state's School Nurse Funding Initiative to add 100 nurses in high-need schools in order to get closer to meeting nationally recommended ratios. The 2018 budget bill, Session Law 2018-15, included \$10 million in nonrecurring grants for schools to add school mental health support personnel (defined as nurses, counselors, psychologists, and social workers). (The Program Evaluation Division of the General Assembly released a report in May 2017 stating it would cost \$45 to \$75 million annually to meet national recommendations for the numbers of nurses in schools.)

Funding for a birth certificate initiative of the Perinatal Quality Collaborative of NC:

The 2018 budget bill included funding to support a project of the Perinatal Quality Collaborative of NC intended to improve the accuracy of birth certificate data.

Endorsed: Some recurring funding for the QuitlineNC and You Quit Two Quit perinatal tobacco cessation programs. The CFTF had endorsed the efforts of others to advance \$3 million in additional funding for QuitlineNC, a statewide tobacco cessation program. The 2018 budget contained \$250,000 in additional recurring funds for both QuitlineNC and the You Quit Two Quit Program (a perinatal tobacco cessation program supported on previous action agendas by the CFTF).

Endorsed: Some funding to support tobacco prevention for youth. The CFTF had endorsed the efforts of others to advance \$7 million in state funding for youth tobacco prevention. The 2018 budget contained an additional \$250,000 in nonrecurring funds for youth tobacco prevention programs.

2019

Note about unique 2019 legislative

session: A highly unusual outcome of the 2019 legislative session was that the 2019 Appropriations Act, HB 966, never became law. This bill was ratified by the legislature, was vetoed by the governor, then the House voted to override the veto, but the Senate never voted on the veto override. Some of the 2019 recommendations of the Child Fatality Task Force were addressed in HB 966, but they did not fully advance, since HB 966 itself did not fully advance. Some other bills addressing appropriations referred to as “mini budget bills” did pass in 2019.

Partially Advanced: Firearm Safe Storage Initiative. Two 2019 bills addressed the 2019 Task Force’s recommendation to launch and fund a firearm safety initiative. Originally introduced in 2019 as House Bill 508, the bill had bipartisan support. The text of this bill was then included in House Bill 966, the 2019 Appropriations Act, which was ratified but never became law. This initiative by DHHS was to educate the public about the importance of the safe storage of firearms, to facilitate the distribution of gun locks, and to provide outreach and technical assistance to help communities launch local safe storage initiatives. On August 12, 2019, Governor Cooper signed a gun safety Executive Directive, and this directive set in motion the development and compilation of firearm safety tools and resources by the Division of Public Health, using elements of the Child Fatality Task Force’s firearm safety stakeholder recommendations to inform this work. A webpage on the Division of Public Health website now provides information on firearm safety.

Partially Advanced: Strengthening of the North Carolina Child Fatality Prevention System. Two 2019 bills addressed Task Force’s recommendations to strengthen the statewide Child Fatality Prevention System. House Bill 825 addressed these recommendations, then the text of HB 825 was included in the 2019 Appropriations Act, HB 966, which was ratified but did not become law. The recommendations of the Task Force were adopted in the Child Welfare Reform Plan Final Report submitted by the Center for the Support of Families to the State of North Carolina Office of State Budget and Management and Department of Health and Human Services. The Department of Health and Human Services has already undertaken further study and planning related to these recommendations, as the recommendations are also aligned with current NCDHHS priorities and the statewide Early Childhood Action Plan.

Funding for more school nurses. S.L. 2019-222 includes additional funding in the Department of Public Instruction's instructional support allotment to be used during the fiscal biennium 2019-2021 to improve student mental health by increasing the number of school mental health support personnel (school nurses, counselors, psychologists, and social workers) in each local school administrative unit. The Child Fatality Task Force was one of multiple organizations advancing a recommendation to fund more school nurses.

The CFTF was one of many seeking funding for Raise the Age implementation. In 2017, North Carolina became the last state in the nation to pass a law to raise the age of juvenile court jurisdiction so that 16- and 17-year-olds charged with most crimes and infractions would be dealt with in the Juvenile Court system rather than adult system. Funds were needed to implement "Raise the Age," which went into effect in December 2019, and in the 2019 legislative session, S.L. 2019-229 appropriated funds to add court personnel (clerks, judges, attorneys), additional staff and support for the Division of Juvenile Justice, juvenile court counselors, support for centers serving juveniles, and for other purposes. Many organizations worked to advance this funding.

Full Circle: Reports from outside groups that undertook studies originating from Child Fatality Task Force work

Perinatal Study Report: In 2019 the CFTF advanced legislation to require NCDHHS to study the current status of North Carolina delivering hospitals related to capabilities for handling various complexity levels of care for mothers and newborns. (See further explanation above for this item in 2019.) As a result of this legislation, a Perinatal Systems of Care Task Force was convened by the North Carolina Institute of Medicine, and a report with recommendations from this group was presented to the Joint Legislative Oversight Committee on Health and Human

Services in March 2020. The report was also presented to the Perinatal Health Committee of the Child Fatality Task Force.

Paid Family Leave Insurance Study: In recent years the Child Fatality Task Force heard from experts about the impacts of paid family leave and paid family leave insurance programs in effect in some other states. Realizing the complexities of a statewide paid family leave insurance program, the Task Force determined in 2017 an in-depth study of this issue would need to take place, but that such a study was beyond the scope of Task Force structure and capacity. A multi-sector group was formed for the purpose of outlining the various issues such a study would need to address in order to inform North Carolina leaders about this issue. Using the outline created by this group as a framework, faculty at the Duke University Center for Child and Family Policy elected to perform a pro bono study analyzing the costs and benefits of a potential paid family leave insurance program in North Carolina. This study was published by Duke University in March 2019 and was presented to the full Task Force and the Task Force Perinatal Health Committee during its 2019-2020 study cycle.

2020

Note about unique 2020 legislative session:

The 2020 legislative session was like no other, as it took place in the midst of the COVID-19 global pandemic. Among the many unique features of this session: the legislature was reacting to revenue forecasts in May of 2020 estimating a \$4.2 billion cumulative reduction to FY2019-21 budgeted revenues and that budgeted revenues would be insufficient by nearly \$600 million to support the FY 2019-21 enacted appropriations; the legislature had to address the appropriation of COVID-19 relief funding that had come from the federal government with specific parameters; instead of a comprehensive budget bill being

introduced as is typical, a series of budget bills was introduced; far fewer bills (on any topic) were filed than would typically be filed in a short session as the overwhelming focus of the session was on issues directly related to the COVID-19 pandemic.

New law requiring suicide prevention training for school personnel and a risk referral protocol in schools. For several years, the CFTF has recommended required suicide prevention training for school personnel and a risk referral protocol in schools. In 2020, a bill passed that addresses this recommendation as part of a larger student mental health bill that requires a school-based mental health plan and mental health training on a number of topics beyond suicide prevention. [S.L. 2020-7] [Many stakeholders were involved in this bill and the Task Force was focused only on the suicide prevention aspects of the bill.]

Continued work to plan for a restructured and strengthened North Carolina Child Fatality Prevention System. In 2020, the Department of Health and Human Services continued its study and planning related to Task Force recommendations to strengthen the statewide Child Fatality Prevention System, collaborating with various subject matter experts including some members of the Task Force Executive Committee. This work included formation of a DHHS work group to discuss goals and structure of a new state office of child fatality prevention, interviews with other states related to their fatality review systems and Citizen Review Panels, and consultation with national and state experts. DHHS also partnered with the North Carolina Institute of Medicine to convene stakeholders from across the state whose local or state-level work overlaps with the Child Fatality Prevention System to get their input on various aspects of restructuring implementation.

Improved education and awareness surrounding child abuse and neglect reporting. The 2020 CFTF Action Agenda included administrative items focused on improving education and awareness surrounding child abuse and neglect reporting. The North Carolina Division of Social Services (DSS) and Prevent Child Abuse North Carolina (PCANC) have made progress related to these administrative items. For example, DSS greatly improved the quality and quantity of the content as well as the web navigation and searchability related to the topic of child abuse and neglect reporting on the NC DSS and DHHS website, NCCARE360 now includes information on CAN reporting, and NCDHHS has a webpage with various hotlines that now includes the county contact list to call to report CAN. PCANC is updating and strengthening its free online CAN reporting training now also available Spanish, and they are employing numerous online resources and social media tools to disseminate information about CAN reporting. PCANC also created flyers targeting educators and essential workers to help educate these individuals on how they play a role during pandemic-related shutdowns of recognizing and reporting suspicions of abuse and neglect.



Report from North Carolina Child Fatality Prevention Team

The North Carolina Child Fatality Prevention Team (known as the “State Team”) is composed of nine ex officio and two appointed members, with the North Carolina Chief Medical Examiner serving as chair of the State Team and child fatality prevention staff from that office who support the work of the team. This is a multidisciplinary team with members representing agencies including legal, social services, law enforcement, medical and mental health, education, and the public. The State Team reviews deaths attributed to child abuse and neglect as well as other means of deaths of children under the age of 18 years that are investigated by the North Carolina Medical Examiner System. The Child Fatality Prevention staff reviews all child fatalities in North Carolina that are investigated by the statewide Medical Examiner system. This includes approximately 500 child deaths per year.

Deaths investigated by medical examiners include apparent accidents, homicides, suicides, violent deaths, deaths occurring under suspicious circumstances, and sudden and unexpected deaths of children in apparent good health. Child fatality reviews provide a detailed analysis of factors that may have contributed to a child’s death. The information gained from these reviews is used by the State Team for the purpose of making recommendations to the NC Child Fatality Task Force to support the creation of, or change in, laws, rules or policies in an effort to promote the safety and well-being of children in North Carolina.

Activities of the State Team with CFPT staff include the following:

- Periodic State Team meetings to review and discuss child fatality cases
- Review of local team recommendations
- Development of policy recommendations to submit to the NC Child Fatality Task Force
- Presentation of policy recommendations to the NC Child Fatality Task Force
- Refinement of process and timelines for recommendation development and submission
- Regular review and updating of the law enforcement investigation check list in an effort to collect the most detailed and pertinent information for each child death
- Maintaining a State Team Manual
- Maintaining a website to provide access and information to the community
- Providing specialized training in death scene reconstruction
- Providing data to prevention partners, the media, and researchers
- Providing state-wide child death investigation trainings
- Creating reports and presentations for a variety of relevant agencies and organizations focused on child well-being
- Creating new and strengthening existing relationships with child fatality prevention partners

2020 STATE TEAM RECOMMENDATIONS

1. Training on Reducing Access to Lethal Means

As access to lethal means continues to be an issue among child fatalities, the NC CFPT supports efforts of prevention (e.g. CALM/SAVE MiliVetFam) to be supported and expanded.

2. Firearm Safety/Safe storage

This recommendation for safe storage of firearms had two components:

- Support firearm safety education and awareness of the importance of safe storage;
- Continued education and awareness with an emphasis on safety planning and reducing access to lethal means. Training for school personnel, first responders and school and community health and behavioral health care providers, such as CALM (Counseling on Access to Lethal Means) as an evidence informed effective strategy routinely used as part of daily practice with children and youth to promote safety planning and reduce access to lethal means.

3. Student school support

Increased specialized instructional support personnel (school nurses, school counselors, school social workers, school psychologists) to meet national recommended ratios.

4. Child Abuse/Neglect Reporting

The NC CFPT recommended the following:

- Continued focus on statewide strategies for education on awareness of the NC mandatory reporting law

- Increased training to professionals on what and how to make a report.
- Campaign or public service announcement on education and training for the public

5. Safe Sleep

NC Child Fatality Task Force perinatal health committee study expanding efforts of the UNC Center for Maternal and Infant Health Safe Sleep program to promote best practices for infant safe sleep across the state as well as endorse education and awareness of safe sleep practices and the risks of unsafe sleep environments, including accidental asphyxiation.

6. Support for Department of Social Services

Support DSS recruitment, retention, resources, resilience and training (e.g. support trauma practice model/education, salaries, and positions).

DATA EXPLANATION AND AVAILABILITY

Reports and information for child fatality reviews are collected from public and confidential sources. The information collected by the CFPT can only be released in aggregate form.

At the time of publication of this report, some 2019 cases are pending which prevents the release of a full report from the State Team on 2019 child death data.

Detailed reports of child fatality data can be found at www.ocme.dhhs.nc.gov. Additional reports and data may be available on request by calling (919)743-9058.



Child Fatality Task Force Contact Information and Leadership Structure

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COMMITTEES

The Intentional Death Prevention Committee focuses on preventing homicide, suicide, child abuse, and neglect.

Co-Chairs: **Jennifer Kristiansen**, Director of Social Services, Chatham County

Brett Loftis, CEO, Crossnore School and Children's Home

The Perinatal Health Committee focuses on the reduction of infant mortality with emphasis on perinatal conditions, birth defects, and SIDS.

Co-Chairs: **Belinda Pettiford**, Branch Head, Women's Health Branch, Women's and Children's Health Section, Division of Public Health, Department of Health and Human Services

Dr. Sarah Verbiest, Executive Director, UNC-CH Center for Maternal and Infant Health; Director, Jordan Institute for Families

The Unintentional Death Prevention Committee focuses on preventing unintentional child deaths, such as those due to motor vehicles, poisoning, and fire.

Co-Chairs: **Alan Dellapenna**, Branch Head, Injury and Violence Prevention Branch, Chronic Disease and Injury Section, Division of Public Health, NC Department of Health and Human Services

Martha Sue Hall, Mayor Pro Tempore, City of Albemarle



NC Child Fatality Task Force Members*

Cindy Bizzell

Administrator, Guardian Ad Litem Program, Administrative Office of the Courts

Senator Jim Burgin

NC Senate

Brent Culbertson

Assistant Director, State Bureau of Investigation

Senator Don Davis

NC Senate

Arianna Del Palazzo

County Commissioner, Lee County

John Dickerson

Public Member

Dr. Ellen Essick

Section Chief, NC Healthy Schools, DPI

Martha Sue Hall

Mayor Pro Tempore, Albemarle City Council

Eric Harbour

Child Mental Health Lead, Division of Mental Health/Developmental Disabilities and Substance Abuse Services, NCDHHS

John P. Harris

Brevard Chief of Police

Representative Craig Horn

NC House of Representatives

Michelle Hughes

Executive Director, NC Child

Representative Perrin Jones

NC House of Representatives

Trishana Jones

Programs Director, NC Coalition Against Domestic Violence

Senator Todd Johnson

NC Senate

Dr. Kelly Kimple

Section Chief, Women's & Children's Health, Division of Public Health, NCDHHS

Sarah Kirkman

Conference of District Attorneys

Jennifer Kristiansen

Director of Social Services Chatham County

Representative Donny Lambeth

NC House of Representatives

William Lassiter

Deputy Secretary for Juvenile Justice, DPS

Dr. Martin McCaffrey

Perinatal Quality Collaborative of NC

Karen McLeod

CEO, Benchmarks

Joe Maimone

Director, Center for Safer Schools

Senator Jim Perry

NC Senate

Katherine Pope

Public Member

Dr. Michelle Aurelius

NC Chief Medical Examiner, Division of Public Health, NCDHHS

Representative Howard Hunter

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Bruce Robistow

Health Director, Halifax County

Senator Vickie Sawyer

NC Senate

Bradford Sneed

Legislative Counsel, NC Department of Justice

Pamela T. Thompson

Alamance-Burlington School Board

Dr. Betsey Tilson

State Health Director & Chief Medical Officer, NCDHHS

Dr. Sarah Verbiest

Executive Director, UNC Center for Maternal and Infant Health; Director, Jordan Institute for Families

Representative Donna White

NC House of Representatives

Mary Williams-Stover

Director, Council for Women & Youth Involvement

**This list reflects membership as it was for most of the 2020-2021 study cycle. Members listed here who departed from the Task Force prior to the conclusion of the study cycle include Rep. Craig Horn, Joe Maimone, and Rep. Perrin Jones.*

